
CMCS Informational Bulletin

DATE: June 5, 2020

FROM: Calder Lynch, Deputy Administrator and Director
Center for Medicaid and CHIP Services (CMCS)

SUBJECT: Medicaid Managed Care Frequently Asked Questions (FAQs) – Medical Loss Ratio

The Centers for Medicare & Medicaid Services' (CMS) Medicaid and Children's Health Insurance Program (CHIP) managed care Final Rule adopted standards for the calculation and reporting of a medical loss ratio (MLR) applicable to Medicaid and CHIP managed care contracts, including contracts with managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs). In Medicaid managed care contracts that started on or after July 1, 2017, states were required to include contract requirements for managed care plans to calculate and report an MLR. CHIP also adopted the Medicaid requirements for calculating and reporting MLRs in 42 CFR 438.8 for CHIP managed care contracts at 42 CFR 457.1203(c) through (f); however, the CHIP requirements were effective for CHIP managed care contracts as of the state fiscal year beginning on or after July 1, 2018. Although we refer to the MLR requirements as part of the Medicaid program in this guidance, this guidance is equally applicable to CHIP managed care entities for contracts and rating periods that begin on or after July 1, 2018, pursuant to § 457.1203.

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) (Pub. L. 115-271, enacted October 24, 2018) modified statute to temporarily allow states to keep a larger percentage of remittances from managed care plans when they don't meet MLR requirements. Section 4001 of the SUPPORT Act amended Section 1903(m) of the Social Security Act to permit states to keep a larger percentage of MLR remittances collected specific to the Expansion group (that is, the group described in subclause (VIII) of section 1902(a)(10)(A)(i) of the Act), an amount consistent with the federal matching rate applicable to the state's traditional Medicaid population (that is, the Federal medical assistance percentage that applies under section 1905(b) of the Act), for a limited period of time.

This FAQ document addresses common questions related to the MLR requirements in 42 CFR 438.8¹ as well as implementation and compliance with the legislative changes made by the SUPPORT Act. We encourage states, managed care plans, and other stakeholders to submit questions to ManagedCareRule@cms.hhs.gov to inform future guidance and FAQs.

¹ This FAQ document also addresses other regulatory requirements in 42 CFR part 438 that relate to MLR, including the requirements in §§ 438.74 and 438.4(b)(9).

The “2016 Final Rule” is the Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability Final Rule, published in the Federal Register on May 6, 2016. 81 FR 27498. It is available at <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>.

Medicaid MLR Standards – 42 CFR 438.8

Q1. What is required for compliance with the Medicaid and CHIP MLR?

A1. The 2016 Final Rule included various MLR-related standards in the actuarial soundness requirements in 42 CFR 438.4 and 438.5; added new minimum standards for the calculation and reporting of an MLR applicable to Medicaid managed care contracts at 42 CFR 438.8; and added requirements for state oversight of MLR reporting at 42 CFR 438.74. In addition, the 2016 Final Rule, in 42 CFR 457.1203, incorporated these MLR standards into the CHIP requirements for managed care plans. 81 FR 27758-59. The aforementioned provisions require that an MLR be calculated, reported, and used in the Medicaid and CHIP managed care rate setting context by establishing, respectively, the substantive standards for how an MLR is calculated and reported by MCOs, PIHPs, and PAHPs (referred to as managed care plans), and state responsibilities in oversight of the MLR standards.

For rating periods starting on or after July 1, 2017, states were required to include the following requirements in their Medicaid managed care plan contracts:

1. Calculate and report an MLR in accordance with the standards laid out in 42 CFR 438.8; and
2. Submit to the state an annual MLR report, as required in 42 CFR 438.8(k), that includes the calculated MLR, the underlying data components and methodologies for allocating expenditures, any remittance owed to the state if applicable, a comparison of the information reported with the audited financial report required under 42 CFR 438.3(m), a description of the aggregation method used under 42 CFR 438.8(i), and the number of member months for each MLR reporting year.

Managed care plans are required to submit the annual report in the time and manner established by the state, which must be within 12 months after the end of the MLR reporting year. For example, if a state operated on a rating period of July 1, 2017 through June 30, 2018, the MLR report would be due to the state sometime between July 1, 2018 and June 30, 2019.

In accordance with 42 CFR 438.74(a), states are required to annually submit to CMS a summary description of the MLR report(s) received from the managed care plans. This summary description must be submitted with the related rate certifications under 42 CFR 438.7. In addition, this summary description must include at least: the amount of the numerator, the amount of the denominator, the MLR percentage achieved, the number of member months, and if applicable any remittances owed by each managed care plan for that MLR reporting year.

For contract rating periods beginning on or after July 1, 2019 for Medicaid managed care contracts, capitation rates must be developed in such a way that the managed care plan would reasonably achieve a medical loss ratio standard of at least 85 percent for the rate year, following

the method laid out in 42 CFR 438.8. This is required as part of the actuarial soundness requirements under 42 CFR 438.4(b)(9). States must also take into account the managed care plan's past MLR, as calculated under 42 CFR 438.8, in the development of the capitation rates consistent with 42 CFR 438.5(b)(5).

As noted above, managed care plans are required to submit the annual report within 12 months of the end of the rating period. Because states will need some time to analyze these reports from the plans to create the summary description of the MLR report(s) received from managed care plans as required under 438.74(a), CMS does not expect to see the first summary MLR reports from states until the contract rating periods beginning on or after July 1, 2020. However, states must still use the MLR data available from plans in the development of rates for contract rating periods starting on or after July 1, 2019.

The MLR and MLR-related parallel requirements for CHIP were effective for CHIP managed care contracts as of the state fiscal year beginning on or after July 1, 2018.

Q2. Are states required to implement a minimum MLR or require an MLR remittance?

A2. In general, while CMS believes that a minimum MLR with a remittance requirement is a reasonable and effective program integrity approach to ensure high quality of care and appropriate service delivery in Medicaid managed care programs, states are **not** required to set a minimum MLR or require a remittance under federal law. However, 42 CFR 438.8(c) requires that if a state elects to mandate a minimum MLR for its managed care plans, the minimum MLR must be equal to or higher than 85 percent and must be calculated and reported for each MLR reporting year consistent with 42 CFR 438.8. Likewise, under 42 CFR 438.8(j), if required by the state, the managed care plan must provide a remittance for an MLR reporting year if the MLR for that MLR reporting year does not meet the minimum MLR standard of 85 percent (or higher if set by the state). For contract rating periods beginning on or after July 1, 2019, actuarially sound capitation rates must be developed in such a way that the managed care plan would reasonably achieve a medical loss ratio standard, as calculated under 42 CFR 438.8, of at least 85 percent for the rate year.

Regardless of whether a state elects to mandate a minimum MLR, all states must ensure that managed care plans **calculate and report** an MLR in accordance with the requirements in 42 CFR 438.8. Such requirements must be included in Medicaid managed care contracts starting on or after July 1, 2017. For contract rating periods beginning on or after July 1, 2019, states are also required to annually submit to CMS a summary description of the MLR reports they receive from their Medicaid and CHIP managed care plans with the related rate certifications.

Q3. What are the requirements on states that collect a remittance from managed care plans if the minimum MLR is not met?

A3. If required by the state, a managed care plan must provide a remittance for an MLR reporting year if the MLR for that MLR reporting year does not meet the minimum MLR standard of 85% or higher if set by the state. The regulation at 42 CFR 438.8 does not set the methodology for calculating or collecting remittances. As stated in the 2016 Final Rule (81 FR

27532), because remittances would be imposed under state authority, we believe the state is best suited to determine the methodology for remittances and therefore has the flexibility to set its own methodology. For example, states could decide to use the standard single MLR reporting year data or a 3-year data average for determining any remittance owed; such a decision is within a state's discretion. Regardless of the remittance methodology states elect, the managed care plan must calculate and report an MLR for each MLR reporting year pursuant to 42 CFR 438.8. Additionally, capitation rates for contract rating periods beginning on or after July 1, 2019 must be developed so the managed care plan would reasonably achieve a MLR standard, as calculated under 42 CFR 438.8, of at least 85 percent for the rate year.

Federal regulations, at 42 CFR 438.8(c) and (j), address states' authority to establish a minimum MLR and remittances. If a state elects to mandate a minimum MLR for its managed care plans, 42 CFR 438.8(c) specifies that minimum MLR must be equal to or higher than 85 percent and the MLR must be calculated and reported for each MLR reporting year by the managed care plan. If the state requires a remittance for failure to meet that minimum MLR, 42 CFR 438.8(j) mandates that the managed care plan pay the remittance.

States must also comply with the requirements related to remittances under 42 CFR 438.74(b), which require the return to CMS of the federal government's share of any remittance a state collects, taking into account applicable differences in the federal matching rate (except in those instances outlined in section 1903(m)(9) of the Act as added by Section 4001 of the SUPPORT Act – see Qs 13-18 below). If a remittance is collected, 42 CFR 438.74(b)(2) stipulates the state must also submit a separate report describing the methodology used to determine the state and federal share of the remittance.

We also remind states of the requirements in 42 CFR 438.4(b)(1), which require that any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations.

Q4. How is the MLR reporting year defined?

A4. The MLR reporting year is defined in 42 CFR 438.8(b) as a period of 12 months consistent with the rating period selected by the state. The rating period, as defined by 42 CFR 438.2, is the period of 12 months selected by the State for which the actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS as required by §438.7(a).

However, CMS acknowledges that there are limited situations when the rating period would not be 12 months. For example, if a state was moving from a rating period that aligned with the calendar year to one that aligned with the state fiscal year (e.g., July 1 through June 30), the state may choose to either have a rating period of 6 months or 18 months to accommodate such a change. In [FAQs published in November 2016](#), CMS indicated it would take unusual circumstances into account when reviewing compliance with the rating period duration requirements. An explanation for using a rating period that differs from 12 months as defined in the regulation in §438.2 must be specified in the rate certification required in §438.7 for such consideration.

In the 2016 Final Rule (81 FR 27522, 27525-27526), we acknowledged that states may choose to align their MLR reporting year with the contract year so long as the MLR reporting year is the same as the rating period, although states would not be permitted to have an MLR reporting year that is more than 12 months. To illustrate this, we've provided the following examples below for a state transitioning from a calendar year rating period to a state fiscal year rating period (July 1 through June 30).

Example 1: State chooses to have a 6 month rating period (January 2018 to June 2018) followed by a rating period that aligned with the state fiscal year (July 2018 to June 2019). In this example, the state could choose to align their MLR reporting years in the same way (a 6 month MLR reporting period from January 2018 to June 2018 followed by a 12 month MLR reporting period from July 2018 to June 2019).

Example 2: State chooses to have an 18 month rating period (January 2017 to June 2018) followed by a 12 month rating period (July 2018 to June 2019). In this example, the state could not choose to align their MLR reporting year with the 18 month rating period. The MLR reporting period would need to remain 12 months. The state could choose to have the MLR calculation done for two 12 month periods with some period of overlap (e.g., January 2017 to December 2017 and July 2017 to June 2018, in which case the period from July 2017 through December 2017 would be included in both 12 month MLR calculations). The state must be clear what the MLR reporting years are in the actuarial certification submitted under 42 CFR 438.7 and take into account any overlap between the 2 MLR reporting years if it exists when determining the remittances (if applicable) on the MCO, PIHP, or PAHP for not meeting the standards developed by the state.

Q5. Is there a reporting template states should require their managed care plans to use?

A5. There is currently no standardized MLR reporting template. CMS may consider in the future developing a standardized template along with reporting specifications for MLR summary reports; we intend that such a template and any reporting specifications would be published on Medicaid.gov so that they could be used on a prospective basis. Until such a standardized template is developed, each state can require managed care plans to report in any format that the state chooses, including using a reporting template created by the state, so long as the report contains the required information outlined in 42 CFR 438.8(k).

The report must contain at least the following information for each MLR reporting year:

1. Total incurred claims
2. Expenditures on quality improving activities
3. Expenditures related to program integrity activities compliant with 42 CFR 438.608(a)(1)-(5), 42 CFR 438.608(a)(7)-(8) and 42 CFR 438.608(b)
4. Non-claims costs
5. Premium revenue
6. Taxes, licensing and regulatory fees
7. Methodology(ies) for allocation of expenditures
8. Any credibility adjustment applied

9. The calculated MLR
10. Any remittance owed to the State if applicable
11. A comparison of the information reported in the MLR report with the audited financial report required under 42 CFR 438.3(m)
12. A description of the aggregation method used under 42 CFR 438.8(i)
13. The number of member months

Q6. Which types of managed care plans must calculate and report an MLR?

A6. The requirements for managed care plans to calculate and report MLRs under 42 CFR 438.8 apply to Medicaid MCOs, PIHPs, and PAHPs. At 42 CFR 457.1203, these same provisions for calculating and reporting an MLR apply to MCOs, PIHPs, and PAHPs that participate in the CHIP program as well.

However, PAHPs that deliver only non-emergency medical transportation (NEMT) do not need to comply with the MLR requirements. Under 42 CFR 438.9, NEMT PAHPs are not required to comply with 42 CFR 438.8. Due to this exemption, CMS does not expect states to apply the related requirements in 42 CFR 438.4(b)(9) to setting the capitation rates for NEMT PAHPs.

Q7. What adjustments are allowed for smaller managed care plans with limited experience?

A7. The 2016 Final Rule provided for a credibility adjustment to account for the potential variation in smaller managed care plans. We acknowledged in the 2016 Final Rule that a smaller managed care plan's reported MLR is more likely to vary, and vary more widely, due to the disproportionate effect random variations can have on smaller managed care plans compared to larger plans with more enrollees. (81 FR 27525, 27759) As defined in 42 CFR 438.8(b), the credibility adjustment is used to account for random statistical variation.

The 2016 Final Rule at 42 CFR 438.8(h) describes the methodology CMS will use to publish credibility factors for plans using the most recently available and complete managed care encounter data or FFS claims data and enrollment data reported by states to CMS. The credibility adjustment is calculated so that a plan receiving a capitation payment that is estimated to have a medical loss ratio of 85 percent would be expected to experience a loss ratio less than 85 percent 1 out of every 4 years, or 25 percent of the time. CMS published a [CMCS Information Bulletin on July 31, 2017](#) that provides the MLR credibility adjustments in accordance with 42 CFR 438.8(h) for rating periods beginning on or after July 1, 2017. CMS will publish updated MLR credibility adjustments as needed to reflect updated data, but states should continue to use the credibility adjustments in that informational bulletin until such time as a new one is published.

Q8. How should plans calculate the plan's premium revenue for the MLR calculation?

A8. Pursuant to 42 CFR 438.8(f), the denominator must equal the managed care plan's adjusted premium revenue, which is the plan's premium revenue (as defined in § 438.8(f)(2)) minus the plan's Federal, State, and local taxes and licensing and regulatory fees (as defined in § 438.8(f)(3)). The adjusted premium revenue is aggregated in accordance with § 438.8(i) unless

the state requires separate reporting and calculation of the MLR for different population groups covered under the contract between the state and the managed care plan.

As noted in 81 FR 27530, the basis for the premium revenue, for purposes of determining the denominator for the MLR calculation, may be either:

1. the direct earned premium as reported on annual financial statements filed with state regulators or
2. the direct earned premium attributable solely to coverage provided in the reporting year that reflects any necessary adjustments (e.g. for withholds that are earned back by the plan) and uses the same run-out period as that for claims.

We anticipate that the only time a managed care plan would use the first approach is when the MLR reporting year is on a calendar year basis since annual financial statements are based on a calendar year. If the MLR reporting year is not on a calendar year basis, the second approach would apply. If, and only if, the capitation payments are changed retroactively, the plan will need to recalculate the MLR – see Question 10 below.

Q9. How should managed care plans calculate the MLR if they cover both Medicare and Medicaid enrollees under an integrated product?

A9. As noted at 81 FR 27525, per the requirements in 42 CFR 438.8, all Medicaid MCOs, PIHPs, and PAHPs need to calculate and report their MLR experience for Medicaid, unless an MLR covering both Medicare and Medicaid experience is calculated and reported consistent with the CMS requirements for an integrated Medicare-Medicaid product approved under a financial alignment demonstration approved under Section 1115A. We note as well that there is a separate MLR requirement for Medicare Advantage plans under 42 CFR Part 422, subpart X.

CMS is further clarifying, if the plan is a Medicare-Medicaid product under the financial alignment demonstration approved under Section 1115A, the plan should include the experience and calculate the MLR consistent with the terms of the specific demonstration. CMS has not created an exception to 42 CFR 438.8 for all integrated Medicare-Medicaid products. Therefore, unless the state has authority to require their plans to calculate the MLR differently than as is required under 42 CFR 438.8, such as under a financial alignment demonstration approved under Section 1115A, the plan must calculate and report their MLR experience for Medicaid only.

Q10. When should plans recalculate the MLR?

A10. Generally, plans should calculate and report the MLR after the conclusion of the MLR reporting year and recalculation is not necessary or permitted if the MLR is calculated correctly using the rules in 42 CFR 438.8. However, under 42 CFR 438.8(m), plans must recalculate the MLR for all MLR reporting years affected where a state makes a permissible retroactive change to capitation payments. If such an adjustment is made, managed care plans must timely submit a new MLR report to the state once the recalculation of the MLR is complete. States should then provide CMS with a revised MLR summary report.

Managed care plans are only permitted to recalculate the MLR when the state makes a

retroactive change to the capitation payments used in the MLR calculation.

Q11. How should payments made to subcontracted third-party vendors that are not directly furnishing covered services to enrollees be accounted for in a Medicaid managed care plan's MLR calculation?

A11. Additional details on the regulatory requirements for treating payments made by managed care plans to subcontracted third-party vendors (e.g. Pharmacy Benefit Managers) can be found in the following Informational bulletin on this topic: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib051519.pdf>.

For the purposes of calculating incurred claims under 42 CFR 438.8(e)(2), a Medicaid managed care plan may only include in incurred claims for Medicaid covered services the amount that the subcontractor actually pays the medical provider or supplier for providing Medicaid covered services to enrollees. Where the subcontractor is performing an administrative function (such as eligibility and coverage verification, claims processing, utilization review, or network development), expenditures and profits on these functions are considered a non-claims administrative expense as described in 42 CFR 438.8(e)(2)(v)(A), and must not be counted as an incurred claim for the purposes of MLR calculations. Therefore, payments to the subcontractor that are not the amount actually paid to a provider or supplier for furnishing covered services must not be included in incurred claims.

The guidance published in May 2019 is a clarification of and is specific to the calculating and reporting requirements in 42 CFR 438.8. As noted earlier, the regulations at 42 CFR 438.8 do not set the methodology for calculating remittances where required by a state. As stated in the 2016 Final Rule (81 FR 27532), remittances would be imposed under state authority and are not required by § 438.8. The applicability of this guidance to the state's MLR remittances would be dependent on the requirements in state contracts. This guidance is not a directive to require remittance or make retrospective changes to existing contracts. CMS encourages states to clarify this requirement with plans on a prospective basis to ensure they have the necessary data for future MLR reporting.

Q12. As states are exploring social determinants of health in their Medicaid programs, does CMS have additional guidance on the use of social determinants of health and how related expenditures should be captured in a state's MLR reporting?

A12. CMS is currently developing additional guidance on the use of social determinants of health in state Medicaid programs; this guidance is also expected to address how such activities should be captured in a plan's MLR reporting. The guidance will be published on Medicaid.gov.

SUPPORT for Patients and Communities Act Medicaid MLR Provision – Section 4001

Q13. What does the provision in the SUPPORT Act on Medicaid MLR remittances mean for states?

A13. Section 4001 of the SUPPORT for Patients and Communities Act, enacted October 24,

2018, amended section 1903(m) of the Act to add a new paragraph (m)(9). Section 1903(m)(9) provides a time-limited authorization (after fiscal year 2020 but before fiscal year 2024) for states that collect an MLR remittance from their Medicaid managed care plans for the eligibility group described in section 1902(a)(10)(A)(i)(VIII) (referred to here as “the Expansion Group”). Section 4001 allows states to apply the state’s regular federal medical assistance percentage (FMAP) match rate (calculated pursuant to section 1905(b) of the Act) for the purposes of determining the federal share of the remittance instead of the higher FMAP match rate specified under 1905(y) for use in connection with the Expansion Group.

Q14. What are the requirements that states must meet in order to qualify for the MLR provision added by Section 4001 of the SUPPORT Act?

A14. In order to qualify, the following conditions must be met:

1. The MLR required by the state must be calculated as prescribed under 42 CFR 438.8(d), as in effect on June 1, 2018.
2. The minimum MLR required must also be equal to 85 percent, unless the state had a higher minimum MLR for the Expansion group in place as of May 31, 2018, and elects to use a minimum MLR that is higher than 85 percent and lower than or equal to the higher minimum MLR used as of May 31, 2018.
3. The state received a remittance from the plan (an MCO, PIHP or PAHP) due to its failure to meet the minimum MLR requirement. This remittance must be specific to the Expansion population.
4. The remittance must be related to capitation rate or premium expenditures incurred by states after fiscal year 2020 and before fiscal year 2024. (See Question 15 below.)

For reporting purposes, CMS will require the state to:

1. Isolate the MLR for the Expansion group from other populations.
2. Require plans to submit each of the required components of the MLR report (referenced in the answer to Question 5 above) specific to this population, either in a separate MLR report or as part of the larger MLR report but separately identified (e.g. in a separate appendix).
3. Isolate the MLR findings for this population from other populations in the annual summary description submitted by states to CMS of the plan level MLR findings. States can elect to do so by submitting a separate MLR summary report specific to this population or as part of the larger MLR summary report but separately identified (e.g. in a separate appendix).

States will also need to isolate the MLR findings for this population in the report submitted by states to CMS describing the methodology used to determine the state and federal share of the remittance as required in 42 CFR 438.74. States can elect to do so by submitting a separate report specific to this population or as part of the larger report but separately identified (e.g. in a separate appendix).”

Q15. Does the SUPPORT Act MLR provision affect how states incorporate the MLR into their managed care capitation rate development?

A15. No. The SUPPORT Act MLR provision is a time-limited authorization that only affects the match rate applied to remittances that comply with the requirements noted above. The requirements in 42 CFR 438.4(b)(1), which require that any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations, remain in effect.

Q16. Based on the timeframes in the SUPPORT Act MLR provision, what expenditures would qualify for use of the regular FMAP rate to calculate the federal share of the MLR remittance?

A16. The SUPPORT Act MLR provision applies to expenditures incurred by states for payment for medical assistance provided by an MCO, PIHP or PAHP for the Expansion group after federal fiscal year 2020 and before federal fiscal year 2024. Therefore, this provision will apply to expenditures incurred after the start of federal fiscal year 2020, which is October 1, 2019, and before the start of federal fiscal year 2024, which is October 1, 2023. For states with an MLR reporting period that does not align with the federal fiscal year, states must pro-rate the remittance amount based on the share of capitation payments that fall within this timeframe to determine which expenditures qualify under this provision.

Below are some examples for states that have MLR reporting periods that are on a calendar year basis (Example 1) and a state fiscal year from July to June (Example 2), which are the 2 most common MLR reporting periods. States will need to detail how they are pro-rating the remittance amount in the annual summary description submitted by states to CMS of the plan level MLR findings and in the report submitted by states to CMS describing the methodology used to determine the state and federal share of the remittance as required in 42 CFR 438.74.

Example 1 – State has an MLR reporting period that aligns with the Calendar Year: There would be 3 months of overlap between the 2019 MLR reporting period and the period that the SUPPORT Act MLR provision would be in effect – specifically October, November and December 2019. In this instance, States must pro-rate the remittance owed for this period based on the share of the capitation payments actually made during the months of October, November, and December compared to the total amounts paid during calendar year 2019. These states would also do the same for the period of their CY 2023 MLR reporting period that overlaps with the period that the SUPPORT Act MLR provision would be in effect – January through September 2023.

Example 2 – State has an MLR reporting period that aligns with a State Fiscal Year (July – June): There would be 9 months of overlap between the SFY 2020 MLR reporting period and the period that the SUPPORT Act MLR provision would be in effect – specifically October 2019 through June 2020. In this instance, States must pro-rate the remittance owed for this period based on the share of the capitation payments actually made during the months of October 2019 through June 2020 compared to the total amounts paid during state fiscal year 2020. These states would also do the same for the period of their SFY 2024 MLR reporting period that overlaps with the period that the

SUPPORT Act MLR provision would be in effect – July through September 2023.

Q17. How should states claim for the SUPPORT Act MLR provision on the CMS-64?

A17. CMS will be publishing guidance on how to claim for the SUPPORT Act MLR provision in the near future on [Medicaid.gov](https://www.Medicaid.gov).

Q18. How will CMS be monitoring implementation of the SUPPORT Act MLR provision?

A18. CMS intends to continue working with states to conduct financial audits of Medicaid managed care plans' MLR calculations and remittances. One area of focus for these audits will be the implementation of the SUPPORT for Patients and Communities Act MLR provision in those instances states elect to adopt this option. If you have questions or would like to request technical assistance related to this guidance or with respect to the MLR standards applicable to Medicaid and CHIP managed care contracts, please send an email to ManagedCareRule@cms.hhs.gov.