

## **2017 Medicaid Managed Care Rate Development Guide For Rating Periods Starting between January 1, 2017 and June 30, 2017**

### **Introduction**

The Centers for Medicare and Medicaid Services (CMS) is releasing the 2017 Medicaid Managed Care Rate Development Guide for use in setting rates for rating periods starting between January 1, 2017 and June 30, 2017 for managed care programs subject to the actuarial soundness requirements in 42 CFR §438.4 that were effective July 5, 2016.<sup>1</sup> This rate development guide builds upon the 2016 Medicaid Managed Care Rate Development Guide and the experience of states and CMS in completing rate certifications and reviews. The guide also incorporates the moratorium on the health insurance providers fee from the Consolidated Appropriations Act of 2016, Title II, § 201.<sup>2</sup>

This guide outlines federal standards for rate development and describes information that CMS expects states and their actuaries to provide when developing actuarial rate certifications required under 42 CFR 438.7(a). One of the lessons learned from implementation of previous rate development guidance was that our guidance needed to be more detailed to get more consistent and complete documentation included in the rate certifications. We expect that the information outlined in this guide will be included within the rate certification in adequate detail to allow CMS to determine compliance with the applicable provisions of 42 CFR part 438, including that the data, assumptions, and methodologies used for rate development are consistent with generally accepted actuarial principles and practices and that the capitation rates are appropriate for the populations and services to be covered. CMS strives to review states' submissions of rate certification as efficiently as possible, and therefore, this guide describes our expectations for appropriate documentation required as part of each submission to facilitate our review. The

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<sup>1</sup> The Medicaid and CHIP managed care final rule (CMS-2390-F) was published in the Federal Register on May 6, 2016 (available online at <https://www.federalregister.gov/articles/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered>). Under that rule, States must be compliant with rate setting and rate certification provisions at 42 C.F.R. §§ 438.4(a), 438.4(b)(1), 438.4(b)(2), 438.4(b)(5), 438.4(b)(6), 438.5(a), 438.5(g), 438.6(a), 438.6(b)(1), 438.6(b)(2), 438.6(e), 438.7(a), and 438.7(d) as well as provisions that impact rate development including 438.2, 438.3(c) and 438.3(e) as of the effective date of the final rule (July 5, 2016).

<sup>2</sup> This section of the Consolidated Appropriations Act of 2016 suspends collection of the health insurance provider fee for the 2017 calendar year.

failure to include appropriate documentation may result in additional CMS questions and/or requests to obtain the information described in the guide as part of our review.

42 CFR 438.4 requires that capitation rates be actuarially sound meaning that the capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care plan for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the relevant requirements of 42 CFR 438.4(b); for the rating periods beginning before July 1, 2017, the relevant requirements are paragraphs (b)(1), (b)(2), (b)(5) and (b)(6). In applying the regulation standards, CMS will also use these three principles:

- the capitation rates are reasonable and comply with all applicable laws (statutes and regulations) for Medicaid managed care;
- the rate development process complies with all applicable laws (statutes and regulations) for the Medicaid program, including but not limited to eligibility, benefits, financing, any applicable waiver or demonstration requirements, and program integrity; and
- the documentation is sufficient to demonstrate that the rate development process meets the requirements of 42 CFR part 438 and generally accepted actuarial principles and practices.

CMS has developed three sections for this guide. The first section applies to all Medicaid managed care capitation rates. The second section outlines specific concepts that states and their actuaries must consider when developing rates that include long-term services and supports (LTSS). The third section focuses on issues specific to new adult group capitation rates in light of the more limited experience covering this population.

CMS anticipates that most of the information discussed in this guide is already part of ongoing actuarial work and program management in states. We provide the specific elements to be included in the rate certification to ensure consistency in the material that is submitted and transparency for what is included in federal review. At this time, CMS does not prescribe a specific format for supplying this information in the certification although it is expected that each of the relevant sections below are discussed in sufficient detail in the actuarial rate certification. We also expect that the actuarial certification is submitted to CMS as a distinct, stand-alone document.

Throughout this guide, CMS defines the rate certification as both the letter (or attestation) from the actuary that specifically certifies that the rates are actuarially sound and meet the requirements of CMS regulation, as well as any supporting documentation submitted with the letter or attestation, including the actuarial report, other reports, letters, memorandums, other communications, and other workbooks or data. In practice, most states have provided the information requested in the guide in the supporting documentation and not directly in the letter or attestation.

## Section I. Medicaid Managed Care Rates

This section of the guidance is directed to all states setting Medicaid managed care rates that are subject to the actuarial soundness requirements in 42 CFR §438.4(a), (b)(1), (b)(2), (b)(5) and (b)(6). The rate development and documentation standards outlined below are consistent with requirements in 42 CFR part 438 and relevant Actuarial Standards of Practice (ASOP).

Actuaries are required to follow all Actuarial Standards of Practice; particularly relevant are ASOP 1 (Introductory Actuarial Standard of Practice); ASOP 5 (Incurred Health and Disability Claims); ASOP 12 (Risk Classification (for All Practice Areas)); ASOP 23 (Data Quality); ASOP 25 (Credibility Procedures); ASOP 41 (Actuarial Communications); ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies); and ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification). ASOP 49, which became effective on August 1, 2015, is especially relevant because it focuses on the development of Medicaid managed care rates. The new applicable requirements under 42 CFR §438.4 are consistent with ASOP 49.

### 1. General Information

- A. Rate certifications must be done on a 12-month rating period.<sup>3</sup> CMS will consider a time period other than 12-months to address unusual circumstances. For example, CMS will approve a time period other than 12 months for the following reasons:
  - i. when the state is trying to align program rating periods, which may require a rating period longer than one year (but less than two years); or
  - ii. when the state needs to make an amendment to the contract and the rates for an already approved rating period need to be adjusted accordingly.
- B. States and their actuaries must document all the elements described within their rate certifications to provide adequate detail that CMS is able to determine whether the regulatory standards are met. In evaluating the certification, CMS will look to the reasonableness of the information contained in the certification for the purposes of rate development and may require additional information or documentation as necessary to review and approve the rates. States and their actuaries must ensure that the following elements are properly documented:
  - i. data used, including citations to studies, research papers, other states' analyses, or similar secondary data sources;
  - ii. assumptions made, including any basis or justification for the assumption; and
  - iii. methods for analyzing data and developing assumptions and adjustments.

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<sup>3</sup> As required by 42 CFR §438.2, the definition of a rating period is a period of 12 months selected by the State for which the actuarially sound capitation rates are developed and documented in the rate certification.

- C. The rate certification must include an index that documents the page number or the section number for the items described within this guidance. In cases where not all sections of this guidance are relevant for a particular rate certification (i.e., an amended certification that adds a new benefit for part of the year), inapplicable sections of the guidance should be included and marked as “Not Applicable” in the index.
- D. An acceptable rate certification submission, as supported by the assurances from the state, must include the following items and information:
- i. a letter from the certifying actuary, who meets the requirements for an actuary in 42 CFR 438.2, who certifies that the final capitation rates or rate ranges meet the standards in 42 CFR 438.3(c), 438.3(e), 438.4(a), 438.4(b)(1), 438.4(b)(2), 438.4(b)(5), 438.4(b)(6), 438.5(a), 438.5(g), 438.6(a), 438.6(b)(1), 438.6(b)(2), and 438.6(e);
  - ii. the final and certified capitation rates or the final and certified rate ranges for all rate cells and regions;
  - iii. if rate ranges are certified, assurances that the capitation rate for each rate cell is within the certified rate range; and
  - iv. brief descriptions of the following information (to show that the actuary developing and/or certifying the rates has an appropriate understanding of the program for which he or she is setting rates):
    - (a) a summary of the specific state Medicaid managed care programs covered by the certification. This would include, but not be limited to, the types and numbers of managed care plans included in the rate development (e.g., type should include the program type, such as managed care organizations, prepaid inpatient health plans, or prepaid ambulatory health plans; and the general types of benefits offered, such as medical or physical health, behavioral or mental health, dental health, and long-term services and supports), the areas of the state covered by the managed care rates and approximate length of time the managed care program has been in operation.
    - (b) the rating periods covered by the certification.
    - (c) the Medicaid population(s) covered through the managed care programs for which the certification applies.
    - (d) any eligibility or enrollment criteria that could have a significant influence on the specific population to be covered within the managed care program (e.g., the definition of medically frail, or if enrollment in managed care plans is voluntary or mandatory).
    - (e) a general description or list of the benefits that are required to be provided by the managed care plan or plans (e.g., types of medical services, behavioral health or

mental health services, long-term care services, etc.), particularly noting any benefits that are carved out of the managed care program or that are new to the managed care program in that rating period covered.

## 2. Data

- A. The rate certification, as supported by the assurances from the State, must thoroughly describe the data used to develop the capitation rates including:
- i. a description of the data, including:
    - (a) the types of data used, which may include, but is not limited to: fee-for-service claims data; managed care encounter data; health plan financial data; information from program integrity audits; or other Medicaid program data.
    - (b) the age or time periods of all data used.
    - (c) the sources of all data used (e.g., State Medicaid Agency; other state agencies; health plans; or other third parties).
    - (d) if a significant portion of the benefits under the contract with the managed care entity are provided through arrangements with subcontractors that are also paid on a capitated basis (or subcapitated arrangements), a description of the data received from the subcapitated plans or providers; or, if data is not received from the subcapitated plans or providers, a description of how the historical costs related to subcapitated arrangements were developed or verified.
  - ii. information related to the availability and the quality of the data used for rate development, including:
    - (a) the steps taken by the actuary or by others (e.g., State Medicaid Agency; health plans; external quality review organizations; financial auditors; etc.) to validate the data, including:
      - (i) completeness of the data;
      - (ii) accuracy of the data; and
      - (iii) consistency of the data across data sources.
    - (b) a summary of the actuary's assessment of the data.
    - (c) any other concerns that the actuary has over the availability or quality of the data.
  - iii. if fee-for-service claims or managed care encounter data are not used (or are not available), an explanation of why that data was not used (or was not available) and why the data used in rate development is appropriate for setting capitation rates for the populations and services to be covered.

- iv. if managed care encounter data was not used in the rate development, an explanation of why encounter data was not used as well as any review of the encounter data and the concerns identified which led to not including the encounter data.
  - v. if there is any reliance or use of a data book in the rate development, the details of the template and relevant instructions used in the data book.
- B. The rate certification, as supported by the assurances from the State, must thoroughly describe any significant adjustments, and the basis for the adjustments, that are made to the data, including but not limited to adjustments for:
- i. the credibility of the data;
  - ii. completion factors;
  - iii. errors found in the data;
  - iv. changes in the program between the time period from which the data is obtained and the rating period (e.g., changes in the population covered; changes in benefits or services; changes to payment models or reimbursement rates to providers; or changes to the structure of the managed care program); and
  - v. exclusions of certain payments or services from the data.

### **3. Projected Benefit Costs and Trends**

- A. Final capitation rates must comply with 42 CFR 438.4(b)(6) and must be based only upon services described in 42 CFR 438.3(c)(1)(ii) and 438.3(e).
- B. Variations in the assumptions used to develop the projected benefit costs for 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.
- C. The rate certification and supporting documentation must describe the development of the projected benefit costs included in the capitation rates, including:
- i. a description of the data, assumptions, and methodologies used to develop the projected benefit costs and, in particular, all significant and material items in developing the projected benefit costs.
  - ii. any material changes to the data, assumptions, and methodologies used to develop projected benefit costs since the last certification must be described.
- D. The rate certification and supporting documentation must include a section on projected benefit cost trends (i.e., an estimate the projected change in benefit costs from the historical base data period(s) to the rating period of the rate certification).
- i. This section must include:

- (a) any data used or assumptions made in developing projected benefit cost trends, including a description of the sources of those data and assumptions. The descriptions of data and assumptions should include citations whenever possible.
  - (b) the methodologies used to develop projected benefit trends.
  - (c) any comparisons to historical benefit cost trends, or other program benefit cost trends, that were analyzed as part of the development of the trend for the rating period of the rate certification.
- ii. This section must include the projected benefit cost trends separated into components, specifically:
  - (a) the projected benefit cost trends should be separated into:
    - (i) changes in price (i.e., pricing differences due to different provider reimbursement rates or payment models); and
    - (ii) changes in utilization (i.e., differences in the amount, duration, or mix of benefits or services provided).
  - (b) If the actuary did not develop the projected benefit cost trends using price and utilization components, the actuary should describe and justify the method(s) used to develop projected benefit cost trends.
  - (c) The projected benefit cost trends may include other components as applicable and used by the actuary in developing rates (e.g., changes in location of service delivery; the effect of utilization or care management on projected benefit cost trends; regional differences or variations).
- iii. Variations in the projected benefit cost trends must be explained. Projected benefit cost trends may vary by:
  - (a) Medicaid populations;
  - (b) rate cells; or
  - (c) subsets of benefits within a category of services (e.g., specialty vs. non-specialty drugs).
- iv. Any other material adjustments to projected benefit cost trends, including a description of the data, assumptions, and methodologies used to determine those adjustments must be included.
- v. Any other adjustments to projected benefit costs trends must be described, including:
  - (a) the impact of managed care on the utilization and the unit costs of health care services; or

- (b) changes to projected benefit costs trend in the rating period outside of regular changes in utilization or unit cost of services.
- E. If the projected benefit costs include additional services deemed by the State to be necessary to comply with the parity standards of the Mental Health Parity and Addiction Equity Act as required by 42 CFR §438.3(c)(ii), the following must be described:
  - i. the categories of service that contain these services;
  - ii. the percentage of cost that these services represent in each category of service; and
  - iii. how these services were taken into account in the development of the projected benefit costs, and if this approach was different than that for any of the other services in the categories of service.
- F. If the projected benefit costs include costs for in-lieu-of services defined at 42 CFR §438.3(e)(2) (i.e., substitutes for State Plan services or settings), the utilization and unit costs of the in-lieu-of services must be taken into account in developing the projected benefit costs of the relevant State plan services (as opposed to utilization and unit costs of the State plan services), unless a statute or regulation explicitly requires otherwise. The following documentation must be described:
  - i. the categories of service that contain in-lieu-of-services;
  - ii. the percentage of cost that in-lieu-of services represent in each category of service; and
  - iii. how the in-lieu-of services were taken into account in the development of the projected benefit costs, and if this approach was different than that for any of the other services in the categories of service.
- G. States may make a monthly capitation payment to an MCO or PIHP (in a “risk contract” as defined in 42 CFR 438.2) for an enrollee age 21 to 64 receiving inpatient treatment in an Institution for Mental Diseases (IMD) (as defined in 42 CFR 435.1010) for a short-term stay of no more than 15 days during the period of the monthly capitation payment in accordance with 42 CFR 438.6(e). In these cases, when developing the projected benefit costs for these services, the actuary must use the unit costs of providers delivering the same services included in the State plan. The actuary may use the utilization of the services provided to an enrollee in an IMD in developing the projected benefit costs. The data used for developing the projected benefit costs for these services must not include:
  - i. costs associated with an IMD stay of more than 15 days;
  - ii. any other managed care plan costs for services delivered in a month when an enrollee has an IMD stay of more than 15 days; and



- iii. a member month for any month when an enrollee has an IMD stay of more than 15 days

The data and assumptions should be described in the certification.

- H. The rate certification must describe how retrospective eligibility periods are accounted for in rate development, including but not limited to:
  - i. the managed care plan's responsibility to pay for claims incurred during the retroactive eligibility period;
  - ii. how the claims information are included in the base data;
  - iii. how the enrollment or exposure information is included in the base data; and
  - iv. how the capitation rates are adjusted to reflect the retroactive eligibility period, and the assumptions and methodologies used to develop those adjustments.
- I. The rate certification must clearly document the final projected benefit costs by relevant level of detail (e.g., rate cell, or aligned with how the State makes payments to the plans).
- J. The rate certification must clearly document the impact on projected costs for all material changes to covered benefits or services since the last rate certification, including but not limited to:
  - i. more or fewer state plan benefits covered by Medicaid managed care;
  - ii. requirements related to payments from health plans to any providers or class of providers;
  - iii. requirements or conditions of any applicable waivers; or
  - iv. requirements or conditions of any litigation to which the state is subjected.
- K. For each change related to covered benefits or services, the rate certification must include an estimated impact of the change on the amount of projected benefit costs and a description of the data, assumptions, and methodologies used to develop the adjustment. Any change not determined by the actuary to be material can be grouped with other non-material changes and described within the rate certification. If this is done, the actuary must give a description of why the changes were not considered material and how they were aggregated into a single adjustment.

#### **4. Pass-Through Payments**

- A. A pass-through payment is any amount required by the State to be added to the contracted payment rates between MCOs, PIHPs, or PAHPs and hospitals, physicians, or nursing facilities that is not for one of the following purposes:
  - i. a specific service or benefit provided to a specific enrollee covered under the contract;

- ii. a provider payment methodology permitted under 42 CFR 438.6(c)(1)(i) through (iii) for services and enrollees covered under the contract;<sup>4</sup>
  - iii. a subcapitated payment arrangement for a specific set of services and enrollees covered under the contract;
  - iv. graduate Medical Education (GME) payments; or
  - v. Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) wrap around payments.
- B. The rate certification and supporting documentation must describe all existing pass-through payments included in the rates for this rating period, including:
- i. a description of the pass-through payment;
  - ii. the amount of the pass-through payments, both in total and on a per member per month basis (if applicable);
  - iii. the providers receiving the pass-through payments;
  - iv. the financing mechanism for the pass-through payment;
  - v. the amount of pass-through payments made to providers in previous years. In general, this should include the same years of historical claims data and financial data used to develop the rates; and
- C. A common practice in fee-for-service methodologies in Medicaid is to pay providers a supplemental amount beyond the reimbursement rate for the service (e.g., upper payment limit (UPL) payments and disproportionate share hospital (DSH) payments). If states are using a supplemental payment methodology in fee-for-service, it may cause the fee-for-service fee schedule to be lower than a managed care plans' expected negotiated rate. Hence, it may be reasonable to assume higher reimbursements on a per-service basis when looking at the projected benefit costs under managed care in order to ensure that the plan has sufficient capitation rates to cover the expected costs of the enrollees. When transitioning from fee-for-service to managed care, and therefore incorporating a fee-for-service supplemental payment into managed care rates, the actuary must describe:
- i. a description of the supplemental payment;
  - ii. the total amount of the supplemental payments;
  - iii. the providers who received the supplemental payments under fee-for-service;
  - iv. the methodology that the actuary used to incorporate the supplemental payment into the capitation rates; and

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<sup>4</sup> Please note that States must be in compliance with 42 CFR 438.6(c) by the rating period for managed care contracts beginning on or after July 1, 2017.

- v. any payment mechanisms associated with incorporating the supplemental payment into the capitation rates.

## 5. Projected Non-Benefit Costs

- A. Variations in the assumptions used to develop the projected non-benefit costs for 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.
- B. The rate certification and supporting documentation must describe the development of the projected non-benefit costs included in the capitation rates, including:
  - i. a description of the data, assumptions, and methodologies used to develop the projected non-benefit costs, and in particular, all significant and material items in developing the projected non-benefit costs.
  - ii. any material changes to the data, assumptions, and methodologies used to develop projected non-benefit costs since the last rate certification.
- C. States and actuaries must estimate the projected non-benefit costs for each of the following categories of costs:
  - i. administrative costs;
  - ii. care coordination and care management;
  - iii. provision for margin (which may include profit margin, operating margin, risk margin, contingency margin, cost of capital, or underwriting gain);
  - iv. taxes, fees, and assessments; and
  - v. other material non-benefit costs.
- D. Non-benefit costs may be developed as per member per month (PMPM) costs or as a percentage of projected benefit costs or capitation rates, and different approaches can be taken for different categories of costs. For non-benefit costs that may be difficult to allocate to specific enrollees or groups of enrollees, or for taxes and fees that are assessed as a percentage of premiums, it may be reasonable to calculate those non-benefit costs as a percentage of benefit costs or capitation rates.
- E. Regarding the Health Insurance Providers Fee (HIPF), CMS issued guidance in October 2014 (Medicaid and CHIP FAQs: Health Insurance Providers Fee for Medicaid Managed Care Plans, <http://medicaid.gov/federal-policy-guidance/downloads/faq-10-06-2014.pdf>). The rate certification and supporting documentation must:
  - i. specifically address how this fee is incorporated into capitation rates.

- ii. if the fee is incorporated into the rates in the initial rate certification, an explanation of whether the amount included in the rates is based on the data year or fee year during the rating period of the rate certification.
  - iii. a description of how the amount of the fee was determined, and whether or not any adjustments would be made to the rates once the actual amount of the fee is known.
  - iv. if the fee is not incorporated into the rates in the rate certification because the rates will be adjusted to account for the fee subsequently, an explicit statement that the fee is not included, and a description of when and how the rates will ultimately be adjusted to account for the fee.
  - v. if the capitation rates include benefits as described in 26 CFR §57.2(h)(2)(ix) (e.g., long-term care, nursing home care, home health care, or community-based care), CMS recommends that the per member per month cost associated with those benefits be explicitly reported as a separate amount in the rate certification in order to more accurately account for the appropriate revenue on which the plans will be assessed.
- F. Due to the health insurance provider fee moratorium established by the Consolidated Appropriations Act of 2016, CMS does not expect any health insurance provider fees to be collected in calendar year 2017. Therefore, no amounts should be included in Medicaid managed care capitation rates for fees that would have been paid by plans to the IRS in 2017 (which would have been assessed off of 2016 net premiums). More information can be found here:

<https://www.irs.gov/Businesses/Corporations/Affordable-Care-Act-Provision-9010>

## **6. Rate Range Development**

- A. In cases when the actuary develops and certifies rate ranges on behalf of a state, the rate certification and supporting documentation must describe how the rate ranges were developed, including:
- i. any assumptions for which values vary in order to develop rate ranges;
  - ii. the values of each of the assumptions used to develop the minimum, the mid-point or best estimate (as applicable), and the maximum of the rate ranges; and
  - iii. a description of the data, assumptions, and methodologies that were used to develop the values of the assumptions for the minimum, the mid-point or best estimate (as applicable), and the maximum of the rate ranges.
- B. The information related to rate range development must be included in either the relevant sections of the rate certification or in a separate section related specifically to the rate range development. For example, a description of how certain assumptions related to projected benefit costs vary to develop the rate ranges may be included with the description of other information related to projected benefit costs, or may be included in a

section that describes all of the assumptions that were varied to develop the rates. The certification index, described in Section I, Item 1.C, must note where these are described.

## **7. Risk Mitigation, Incentives and Related Contractual Provisions**

- A. The rate certification and supporting documentation must describe any risk mitigation, incentives, or similar contractual provisions that may affect the rates, rate ranges, or the final net payments to the health plans under the applicable contract.
- B. The rate certification and supporting documentation must specifically address:
  - i. the risk adjustment model(s) being used to calculate risk scores;
  - ii. the specific data, including the source(s) of the data, being used by the risk adjustment model(s), including any adjustments made to the data;
  - iii. any changes that are made to risk adjustment model (e.g. conditions for excluding enrollees or data from the risk adjustment model, changes in how the risk scores are determined);
  - iv. how frequently the risk scores are calculated;
  - v. how the risk scores are being used to adjust the capitation rates; and
  - vi. an attestation that the risk adjustment model is cost neutral. (42 CFR §438.5(g).)
- C. The rate certification and supporting documentation must indicate if a risk-sharing model is being used to account for the health status of the population in a manner that is not cost neutral (i.e., in a manner that may cause the total projected costs to increase or decrease based on the actual health status of the population). These types of risk-sharing models should only be used prospectively as part of the rate development process and not to adjust the final capitation rates or payments to managed care plans (e.g., estimating how projected changes in the risk of the Medicaid population may effect projected benefit costs). CMS may also consider these as a risk mitigation strategy when there is unusual and significant uncertainty about the health status of the population (e.g., covering a new population in Medicaid). CMS characterizes this type of adjustment as an “Acuity Adjustment.” If an acuity adjustment is being used, the rate certification should include:
  - i. the reason that there is significant uncertainty about the health status of the population and the need for an acuity adjustment;
  - ii. the risk adjustment or acuity adjustment model(s) being used to calculate acuity adjustment scores;
  - iii. the specific data, including the source(s) of the data, being used by the risk adjustment or acuity adjustment model(s);

- iv. the relationship and potential interactions between the acuity adjustment and the risk adjustment;
  - v. how frequently the acuity adjustment scores are calculated;
  - vi. a description of how the acuity adjustment scores are being used to adjust the capitation rates; and
  - vii. an attestation that the acuity adjustment mechanism has been developed in accordance with generally accepted actuarial principles and practices.
- D. The rate certification and supporting documentation must detail any other risk-sharing arrangements, such as a risk corridor or a large claims pool. This includes:
- i. a rationale for the use of the risk sharing arrangement;
  - ii. a detailed description of how the risk-sharing arrangement is implemented;
  - iii. a description of any effect that the risk-sharing arrangements have on the development of the capitation rates; and
  - iv. an attestation that the risk-sharing mechanism has been developed in accordance with generally accepted actuarial principles and practices.
- E. If the contract has a medical loss ratio requirements, such as a minimum medical loss ratio requirement, the rate certification and supporting documentation must include:
- i. a detailed description of, or citation for, the methodology used to calculate the medical loss ratio; and
  - ii. a description of the consequences for having a medical loss ratio below the minimum requirements (e.g., financial recovery; contractual penalties).
- F. The rate certification and supporting documentation must provide a detailed description of any reinsurance requirements under the contract associated with the rate certification, including a description of any effect that the reinsurance requirements have on the development of the capitation rates. The rate certification must also include an attestation that the reinsurance mechanism has been developed in accordance with generally accepted actuarial principles and practices.
- G. The rate certification must include an attestation that the incentive arrangement will not exceed 105% of the approved capitation payments under the contract that are attributable to the enrollees or services covered by the incentive arrangement as required in 42 CFR §438.6(b)(2);
- H. The rate certification and supporting documentation must describe any incentives or withhold amounts in the contract between the state and the health plans. The rate certification must include:

- i. a description of the percentage of the certified capitation rates being withheld through withhold arrangements;
- ii. an estimate of the percentage of the withheld amount through a withhold arrangement that is expected to be returned and the basis for that determination; and
- iii. a description of any effect that the incentive or withhold arrangements have on the development of the capitation rates.

## **8. Other Rate Development Considerations**

- A. There are services, populations, or programs for which the state receives a different federal medical assistance percentage (FMAP) than the regular state FMAP. In those cases, the portions or amounts of the costs subject to the different FMAP should be shown as part of the rate certification to the extent possible.
- B. 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.
- C. The effective dates of changes to the Medicaid managed care program (including eligibility, benefits, payment rate requirements, incentive programs, and program initiatives) should be consistent with the assumptions used to develop the capitation rates.
- D. In determining whether the rate certification submission and supporting documentation adequately demonstrate that the rates were developed using generally accepted actuarial practices and principles, CMS will consider the following:
  - i. all adjustments to the capitation rates, or to any portion of the capitation rates, must reflect reasonable, appropriate, and attainable costs in the actuary's judgment and must be included in the rate certification.
  - ii. adjustments to the rates or rate ranges that are performed outside of the rate setting process described in the rate certification are not considered actuarially sound under 42 CFR §438.4. Therefore, the rates or rate ranges will not be considered actuarially sound if adjustments are made outside of the rate setting process described in the rate certification.
  - iii. the final contracted rates in each cell must either match the capitation rates or be within the rate ranges in the rate certification. This is required in total and for each and every rate cell.

## **9. Procedures For Rate Certifications for Rate and Contract Amendments**

- A. CMS requires that the State will submit a new rate certification when the rates or rate ranges change.

- B. For contract amendments that do not affect the rates or rate ranges, CMS does not require a new rate certification from the State.
- C. There are several circumstances when CMS would not require a new rate certification:
  - i. a state changes the capitation rates paid to the plans, but the capitation rates still fall within the certified rate ranges for that rating period and contract.
  - ii. a state applies risk scores to the capitation rates paid to the plans under a risk adjustment methodology described in the certification for that rating period and contract.
- D. Any time a rate changes for any reason other than application of a risk adjustment methodology which was included in the initial managed care contract, the state must submit a contract amendment to CMS, even if the rate change does not need a new rate certification.

## **Section II. Medicaid Managed Care Rates with Long-Term Services and Supports**

This section of the guidance is directed to all states setting Medicaid managed care rates that are subject to the actuarial soundness requirements in 42 CFR §438.4 and include managed long-term services and supports (MLTSS). In determining whether rates have been developed in accordance with generally accepted actuarial practices and principles, CMS will apply the specific considerations below.

### **1. Managed Long-Term Services and Supports**

- A. For managed long-term services and supports (MLTSS) programs, or for programs that include MLTSS as part of the covered benefits, the guidance above in Section I about the required content of the actuarial rate certification is also applicable for rates for provision of MLTSS.
- B. The rate certification and supporting documentation for MLTSS programs, or for programs that include MLTSS as part of the covered benefits must also specifically address the following considerations:
  - (a) The structure of the capitation rates and rate cells or rating categories. States may take different approaches for rate setting for MLTSS. The two most common approaches are to structure the rate cells:
    - (i) by health care status and the level of need of the beneficiaries (“blended”); or
    - (ii) by the long-term care setting that the beneficiary uses (“non-blended”).



- (b) The structure of the rates and the rate cells, and the data, assumptions, and methodology used to develop the rates in light of the overall rate setting approach. States that are currently using a structure that differentiates rates by long-term care setting will need to describe why a blended rate structure is not feasible at this time and CMS will work with the state to move to a blended rate structure in the coming rating periods in order to align with the 2013 guidance around MLTSS programs found here. <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/1115-and-1915b-mltss-guidance.pdf>
- C. The rate certification must describe the expected effect that managing LTSS has on the utilization and unit costs of services. The certification must describe any effect that the management of this care is expected to have within each care setting and any effect in managing the level of care that the beneficiary receives (e.g., in-home care, community long-term care, nursing facility care).
- D. The projected non-benefit costs, such as administrative costs and care coordination costs, may differ for populations receiving MLTSS from other managed care programs, and the rate certification should describe how the projected non-benefit costs were developed for populations receiving these services.
- E. The rate certification should provide information on historical experience, analysis, and other sources (e.g., studies or research) used to develop the assumptions used for rate setting.

### **Section III. New Adult Group Capitation Rates**

This section of the guidance is focused on rate setting for the new adult group under 1902(a)(10)(A)(i)(VIII) of the Social Security Act. For states that have previously covered the new adult group, this guide describes the information expected from states related to how the capitation rates or the rate development process has changed since the most recent certification. Because this is a newly eligible group, CMS expects that rate development may require additional review in this area to ensure that rates are developed in accordance with generally accepted actuarial practices and principles. To support such review, CMS expects States to provide additional information as described below.

#### **1. Data**

- A. In addition to the expectations for all Medicaid managed care rate certifications, as supported by assurances from the State, described in Section I, the rate certification must describe any data used to develop new adult group rates.

- B. For states that have covered the new adult group in Medicaid managed care plans in 2014, 2015 and/or 2016, CMS expects the rate certification, as supported by assurances from the State, to describe:
- i. any new data that is available for use in 2017 rate setting;
  - ii. how the state and the actuary followed through on any plans to monitor costs and experience for newly eligible adults;
  - iii. how actual experience and costs in 2014, 2015 and/or 2016 have differed from assumptions and expectations in previous rate certifications; and
  - iv. how differences between projected and actual experience in 2014, 2015 and/or 2016 have been used to adjust the 2017 rates.

## **2. Projected Benefit Costs**

- A. In addition to the guidance for all Medicaid managed care rate certifications described in Section I, states should include in the rate certification submission and supporting documentation a description of the following issues related to the projected benefit costs for the new adult group:
- i. For states that covered the new adult group in 2014, 2015 and/or 2016:
    - (a) any data and experience specific to newly eligible adults covered in 2014, 2015 and/or 2016 that was used to develop projected benefits costs for capitation rates.
    - (b) any changes in data sources, assumptions, or methodologies used to develop projected benefits costs for capitation rates since the last certification.
    - (c) how assumptions changed from the 2014, 2015 and/or 2016 rate certification(s) on the following issues:
      - (i) acuity or health status adjustments (in most cases comparing the new adult group enrollees to other Medicaid adult enrollees);
      - (ii) adjustments for pent-up demand;
      - (iii) adjustments for adverse selection;
      - (iv) adjustments for the demographics of newly eligible adults;
      - (v) differences in provider reimbursement rates or provider networks, including any differences between provider reimbursement rates or provider networks for newly eligible adult rates and other Medicaid population rates; and
    - (i) Variations in the assumptions used to develop the projected benefit costs for 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.

- (vi) other material adjustments to newly eligible adults projected benefit costs.
- B. For any state that is covering the new adult group, regardless if they have been covered in 2014, 2015 and/or 2016, the following key assumptions related to the new adult group must be included in the rate certification and supporting documentation:
  - i. acuity or health status adjustments (in most cases comparing new adult group enrollees to other Medicaid adult enrollees);
  - ii. adjustments for pent-up demand;
  - iii. adjustments for adverse selection;
  - iv. adjustments for the demographics of the new adult group;
  - v. differences in provider reimbursement rates or provider networks, including any differences between provider reimbursement rates or provider networks for the new adult group rates and other Medicaid population rates; and
  - vi. other material adjustments to the new adult group projected benefit costs.
- C. The rate certification and supporting documentation must describe any changes to the benefit plan offered to the new adult group.
- D. The rate certification and supporting documentation must describe any other material changes or adjustments to projected benefit costs.

### **3. Projected Non-Benefit Costs**

- A. In addition to the guidance all Medicaid managed care rate certifications described in Section I, states must include in the rate certification submission and supporting documentation a description of the following issues related to the projected non-benefit costs for the new adult group:
  - i. for states that covered the new adult group in Medicaid managed care plans in 2014, 2015 and/or 2016, any changes in data sources, assumptions, or methodologies used to develop projected non-benefit costs since the last rate certification.
  - ii. how assumptions changed from the 2014, 2015 and/or 2016 rate certification(s) on the following issues:
    - (a) administrative costs;
    - (b) care coordination and care management;
    - (c) provision for operating or profit margin;
    - (d) taxes, fees, and assessments; and
    - (e) other material non-benefit costs.

B. The rate certification and supporting documentation must include information on key assumptions related to the new adult group and any differences between the assumptions for this population and the assumptions used to develop projected non-benefit costs for other Medicaid populations for the following issues:

- (a) administrative costs;
- (b) care coordination and care management;
- (c) provision for operating or profit margin;
- (d) taxes, fees, and assessments; and
- (e) other material non-benefit costs.

#### **4. Final Certified Rates or Rate Ranges**

A. In addition to the expectations for all Medicaid managed care rate certifications described in Section I, CMS requests under §438.7(d)<sup>5</sup> that states that covered the new adult group in Medicaid managed care plans in 2014, 2015 and/or 2016 provide:

- i. a comparison to the final certified rates or rate ranges in the previous rate certification; and
- ii. a description of any other material changes to the capitation rates or the rate development process not otherwise addressed in the other sections of this guidance.

#### **5. Risk Mitigation Strategies**

A. CMS requests under §438.7(d) that states describe the risk mitigation strategy specific to the new adult group rates.

B. For states that covered the new adult group in Medicaid managed care plans in 2014, 2015 and/or 2016, CMS requests the following information:

- i. any changes in the risk mitigation strategy from those used during 2014, 2015 and/or 2016;
- ii. the rationale for making the change in the risk mitigation strategy or removing the risk mitigation strategy used during 2014, 2015 and/or 2016; and
- iii. any relevant experience, results, or preliminary information available related to the risk mitigation strategy used during 2014, 2015 and/or 2016.

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<sup>5</sup> The regulation provides: (d) *Provision of additional information*. The State must, upon CMS' request, provide additional information, whether part of the rate certification or additional supplemental materials, if CMS determines that information is pertinent to the approval of the certification under this part. The State must identify whether the information provided in addition to the rate certification is proffered by the State, the actuary, or another party.