DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Disabled and Elderly Health Programs Group

2023-2024 Medicaid Managed Care Rate Development Guide

For Rating Periods Starting between July 1, 2023 and June 30, 2024[1,2]

XX 2023

Introduction

The Centers for Medicare & Medicaid Services (CMS) is releasing the 2023-2024 Medicaid Managed Care Rate Development Guide for use in setting rates for rating periods starting between July 1, 2023, and June 30, 2024 for managed care programs subject to the actuarial soundness requirements in 42 CFR § 438.4.[3,4] This guidance is released in accordance with 42 CFR § 438.7(e). This rate development guide builds upon the Medicaid Managed Care Rate Development Guide effective for rating periods that start between July 1, 2022, through June 30, 2023, and the experience of states and CMS in completing rate certifications and reviews. This rate development guide does not replace or revise the guidance in place for those prior rating

[1] The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

[2] This guide outlines federal standards for rate development in 42 CFR §§ 438.4 through 438.7 and describes information required from states and their actuaries as part of actuarial rate certifications required under 42 CFR § 438.7(a). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is OMB 0938-1148 (CMS-10398 #37). The time required to complete the information collection is estimated to average 5.5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

[3] Except as noted in the regulation text itself, all regulations related to rate setting at 42 CFR §§ 438.4, 438.5, 438.6 and 438.7 are applicable. In addition, States must be compliant with provisions that impact rate development, including 42 CFR §§ 438.2, 438.3(c), 438.3(e), 438.8, 438.14, and 438.608(d).

[4] States must comply with all applicable federal statutory and regulatory requirements as well as guidance that impacts Medicaid managed care rate development. CMS will evaluate if addendums to this rate guide are necessary if any new federal requirements are implemented.

periods. If states or their actuaries have questions regarding this guidance, please contact MMCratesetting@cms.hhs.gov.

This guide outlines federal standards for rate development and describes information required from states and their actuaries as part of actuarial rate certifications required under 42 CFR § 438.7(a). All standards and documentation expectations outlined in this rate development guide for capitation rates also apply for rate ranges developed in accordance with 42 CFR § 438.4(c) unless otherwise stated. The information outlined in this guide must be included within the rate certification in adequate detail to allow CMS (or its actuaries) 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 the required standards for rate development in accordance with 42 CFR § 438.5 and appropriate documentation for each submission in accordance with 42 CFR § 438.7 to facilitate our review. Adherence by states and their actuaries to the rate development standards and documentation expectations outlined in this guide, will aid in ensuring compliance with the regulations and in CMS's review and approval of actuarially sound capitation rates and associated federal financial participation. 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.

Additionally, as part of the CMS effort to review states' submissions of rate certification as efficiently as possible, CMS implemented an accelerated rate review process. Appendix A contains additional information regarding this accelerated rate review process and procedures, specifically the criteria that a state must meet for the capitation rates to be eligible for an accelerated rate review and the rate development summary that states must provide in order to go through an accelerated rate review.

Section 1903(m)(2) of the Social Security Act (the Act) and 42 CFR § 438.4 require 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. Such capitation rates are developed in accordance with 42 CFR § 438.4(b). 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.

This guide is divided into three sections. 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. Additionally, Appendix A outlines information regarding the accelerated rate review process and procedures and Appendix B describes additional documentation required when in lieu of services and settings are utilized.

Most of the information discussed in this guide is or should already be part of ongoing actuarial work and program management in states as part of ensuring compliance with 42 CFR §§ 438.4 through 438.7. CMS provides the specific elements to be included in the rate certification to ensure compliance with the regulations, consistency in the material that is submitted and transparency for what is included in federal review. Following CMS guidance included within this guide is more likely to result in a faster CMS review and reduce the number of questions. At this time, CMS does not prescribe a specific format for supplying this information in the rate certification although each of the relevant sections below must be discussed in sufficient detail in the rate certification, including those specified in 42 CFR § 438.7.

Throughout this guide, CMS uses the term “rate certification” to mean both the letter (or attestation) from the actuary that specifically certifies that the rates are actuarially sound and meets the requirements of CMS regulations and any supporting documentation that relates to the letter or attestation, including the actuarial report, other reports, letters, memorandums, other communications, and other workbooks or data. In practice, most states provide the information requested in the guide in the supporting documentation and not directly in the letter or attestation.

In accordance with 42 CFR § 438.7, states must submit to CMS for review and approval all rate certifications for managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs), concurrent with the review and approval of the contracts. CMS requests that states submit contract actions, rate certification(s) and associated supporting documentation as distinct documents within one submission rather than combining all materials into one electronic document. If multiple rate certifications are associated with the same contract action(s), CMS requests that states provide the supporting documentation that relates to each certification.

Section I. Medicaid Managed Care Rates

This section of the guidance is directed to all states setting Medicaid managed care capitation rates (including rate ranges) subject to the actuarial soundness requirements in 42 CFR § 438.4. The rate development and documentation standards outlined below are consistent with 42 CFR part 438 and relevant Actuarial Standards of Practice (ASOPs). Actuaries are required to follow all ASOPs as part of the obligation to develop rates and certain payment terms in accordance with generally accepted actuarial principles and practices. *See* 42 CFR §§ 438.4 through 438.7. Particularly relevant are ASOP No. 1 (Introductory Actuarial Standard of Practice); ASOP No. 5 (Incurred Health and Disability Claims); ASOP No. 12 (Risk Classification (for All Practice Areas)); ASOP No. 23 (Data Quality); ASOP No. 25 (Credibility Procedures); ASOP No. 41 (Actuarial Communications); ASOP No. 45 (The Use of Health Status Based Risk Adjustment Methodologies); ASOP No. 49 (Medicaid Managed Care Capitation Rate Development and Certification); and ASOP No. 56 (Modeling). ASOP No. 49 is especially relevant because it focuses on the development of Medicaid managed care rates. The applicable requirements under 42 CFR §§ 438.4 and 438.5 are consistent with ASOP No. 49.

1. General Information

A. Rate Development Standards

i. Unless otherwise stated, all standards and documentation expectations outlined in this rate development guide for capitation rates also apply for the development of the upper and lower bounds of rate ranges, in accordance with 42 CFR § 438.4(c).

ii. Rate certifications must be done for a 12-month rating period.[5]

iii. In accordance with 42 CFR §§ 438.4, 438.5, 438.6, and 438.7, an acceptable rate certification submission, as supported by the assurances from the state, includes the following items and information:

(a) 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, 438.5, 438.6, and 438.7.

(b) The final and certified capitation rates or rate ranges for all rate cells in accordance with 42 CFR § 438.4(b)(4) or § 438.4(c) for all regions (as applicable). Additionally, the contract must specify the final capitation rate(s) in accordance with 42 CFR § 438.3(c)(1)(i).

[5] Per 42 CFR § 438.2, "rating period" means 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) 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 developing rates):

(i) A summary of the specific state Medicaid managed care programs covered by the rate certification, including, but not limited to:

(A) The types and numbers of managed care plan(s) included in the rate development (e.g., type means managed care organization(s), prepaid inpatient health plan(s), or prepaid ambulatory health plan(s)), including dual eligible special needs plans (D-SNPs) under contract with a State Medicaid agency.[6]

(B) A general description or list of the benefits that are required to be provided by the managed care plan(s) (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, provided on a non-risk basis by the managed care plan(s), or that are new to the managed care program in the covered rating period.

(C) The geographic areas of the state covered by the managed care rates and approximate length of time the managed care program has been in operation.

(ii) The rating period covered by the rate certification.

(iii) The Medicaid population(s) covered through the managed care program(s) to which the rate certification applies.

(iv) 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 plan(s) is voluntary or mandatory).

[6] As discussed in the preamble of the Final Rule for the Medicare Program: Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs (87 FR 27704), capitation rates developed for Medicaid managed care contracts between a State Medicaid agency and a dual eligible special needs plan (D-SNP) must meet Medicaid managed care actuarial soundness requirements under 42 CFR § 438.4. Under 42 CFR § 422.107(b), Medicare Advantage (MA) organizations seeking to offer a D-SNP defined under 42 CFR § 422.2 must have a contract with the State Medicaid agency that meets the requirements under 42 CFR § 422.107. Such contracts include Medicaid PIHPs and PAHPs serving as the affiliated Medicaid managed care plan for delivery of Medicaid behavioral health or LTSS for highly integrated dual eligible special needs plans (HIDE SNPs) (87 FR 27742) and entities acting as fully integrated special needs plans (FIDE SNPs) (87 FR 27747). The rate certification must ensure any D-SNP is also appropriately identified.

(v) A summary of the special contract provisions related to payment described in 42 CFR § 438.6 (e.g., risk-sharing mechanisms,[7] incentive arrangements, withhold arrangements, state directed payments,[8] pass-through payments, and payments to MCOs and PIHPs for enrollees that are a patient in an Institution of Mental Disease (IMD))[9].

(vi) If the actuary is certifying rates (not rate ranges) and the state and its actuary determine that a retroactive adjustment to the capitation rates is necessary, these retroactive adjustments must be certified by an actuary in a revised rate certification (CMS would accept a new rate certification or rate amendment)[10] and submitted as a contract amendment in accordance with 42 CFR § 438.7(c)(2).[11] The revisions to the rate certification must:

(A) describe the rationale for the adjustment;

(B) describe the data, assumptions and methodologies used to develop the magnitude of the adjustment;

(C) describe whether the state adjusted rates in the rating period by a *de minimis* amount in accordance with 42 CFR § 438.7(c)(3) prior to the submission of the rate amendment; and

(D) address and account for all differences from the most recently certified rates.

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[7] States planning to implement one or more risk mitigation strategy(ies) for a future rating period must submit contract and rate certification documentation to CMS prior to the start of the rating period. This documentation must include contract and rate certification documents that describe the risk mitigation strategy included in the contract between the state and the managed care plan. States must supply this information even if the state implemented the risk corridor (or other risk mitigation provision) in a prior rating period. Examples of risk mitigation include (but are not limited to): reinsurance, stop loss limits, risk corridors, and a minimum MLR with a remittance. For rating periods starting on or after January 1, 2021, submission of contract and rate certification documentation of the final risk mitigation arrangement(s) prior to the start of the rating period is required to meet the regulatory standard of documenting those arrangement(s) to CMS for the rating period prior to the start of the rating period. CMS will accept states' submissions of draft managed care contract actions that are not officially executed and documentation from a state's actuary that may not reflect final full rate development or is limited to a description of the risk sharing arrangement(s). States must submit both contract and rate certification documentation prior to the start of the rating period. The risk mitigation arrangement(s) in the final, executed contract and rate certification documents must be unchanged from the prior submission to CMS for the risk mitigation arrangement(s) to be approvable under 42 CFR 438.6(b)(1).

[8] State direction of managed care plan expenditures under the contract (e.g., value-based purchasing arrangements, multi-payer initiatives, quality/performance incentive programs, and all fee schedules) must meet the requirements in 42 CFR § 438.6(c) and receive prior approval before implementation.

[9] Additional requirements in 42 CFR § 438.6 apply to the various types of special contract provisions; see Section I, Item 4, for more discussion.

[10] The rate guide utilizes the term "rate amendment" throughout this guide to reference an amendment to the initial rate certification.

[11] In accordance with 42 CFR § 438.4(c)(2)(ii), States that use rate ranges are not permitted to modify the capitation rates under 438.7(c)(3).

iv. Any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations must be based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations. Any differences in the assumptions, methodologies, or factors used to develop capitation rates must not vary with the rate of Federal financial participation (FFP) associated with the covered populations in a manner that increases Federal costs. The determination that differences in the assumptions, methodologies, or factors used to develop capitation rates for MCOs, PIHPs, and PAHPs increase Federal costs and vary with the rate of FFP associated with the covered populations must be evaluated for the entire managed care program and include all managed care contracts for all covered populations.[12]

v. Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments from any other rate cell.

vi. The assumptions used for development of the capitation rates must be consistent with the effective dates of changes to the Medicaid managed care program (including but not limited to eligibility, benefits, payment rate requirements, incentive programs, and program initiatives).

vii. Capitation rates must be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio, as calculated under 42 CFR § 438.8, of at least 85 percent for the rate year. The capitation rates may be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard greater than 85 percent, as calculated under 42 CFR § 438.8, as long as the capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs. Under § 438.8(j), the state may choose to impose remittance provisions related to this medical loss ratio. The terms and conditions of any remittance must clearly be outlined in the rate certification and demonstrate compliance with § 438.8(c), which requires a State, that elects to mandate a minimum MLR for its MCOs, PIHPs, or PAHPs, to use a minimum MLR equal to or higher than 85 percent.

viii. In accordance with 42 CFR § 438.4(c), the State and its actuary may develop and certify a range of capitation rates per rate cell as actuarially sound, when all of the following conditions are met:

(a) The rate certification identifies and justifies the assumptions, data, and methodologies specific to both the upper and lower bounds of the rate range.

[12] In accordance with 42 CFR § 438.4(b)(1) and 438.7(d), CMS may require a State to provide written documentation and justification that any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations or contracts represent actual cost differences based on the characteristics and mix of the covered services or the covered populations.

(b) Both the upper and lower bounds of the rate range must be certified as actuarially sound consistent with the requirements of 42 CFR § 438.4.

(c) The upper bound of the rate range does not exceed the lower bound of the rate range multiplied by 1.05.

(d) The rate certification documents the State's criteria for paying MCOs, PIHPs, and PAHPs at different points within the rate range.

(e) The State does not use as a criterion for paying MCOs, PIHPs, and PAHPs at different points within the rate range any of the following:[13]

(i) the willingness or agreement of the MCOs, PIHPs, or PAHPs or their network providers to enter into, or adhere to, intergovernmental transfer (IGT) agreements; or

(ii) the amount of funding the MCOs, PIHPs, or PAHPs or their network providers provide through IGT agreements.

ix. When a State develops and certifies a range of capitation rates per rate cell as actuarially sound consistent with 42 CFR § 438.4(c), the State must:

(a) Document the capitation rates, prior to the start of the rating period, for the MCOs, PIHPs, and PAHPs at points within the rate range, consistent with 42 CFR § 438.4 (c)(1)(iv).

(b) Not modify the capitation rates under 42 CFR § 438.7(c)(3).

(c) Not modify the capitation rates within the rate range, unless the State is increasing or decreasing the capitation rate per rate cell within the rate range up to 1 percent during the rating period. However, any changes of the capitation rate within the permissible 1 percent range must be consistent with a modification of the contract as required in 42 CFR § 438.3(c) and are subject to the requirements of 42 CFR § 438.4(b)(1). Any modification to the capitation rates within the rate range greater than the permissible 1 percent range will require the State to provide a revised rate certification for CMS approval, which demonstrates that:

(i) the criteria in 42 CFR § 438.4(c)(1)(iv), as described in the initial rate certification, were not applied accurately;

(ii) there was a material error in the data, assumptions, or methodologies used to develop the initial rate certification and that the modifications are necessary to correct the error; or

[13] The state's criteria for paying managed care plans at different points within the rate range, must comply with the prohibition in 42 CFR § 438.4(c)(1)(v) and other applicable legal authority.

(iii) other adjustments are appropriate and reasonable to account for programmatic changes.

(d) Post on the website, as required in 42 CFR § 438.10(c)(3), the following information prior to executing a managed care contract or contract amendment that includes or modifies a rate range:

(i) the upper and lower bounds of each rate cell;

(ii) a description of all assumptions that vary between the upper and lower bounds of each rate cell, including for the assumptions that vary, the specific assumptions used for the upper and lower bounds of each rate cell; and

(iii) a description of the data and methodologies that vary between the upper and lower bounds of each rate cell, including for the data and methodologies that vary, the specific data and methodologies used for the upper and lower bounds of each rate cell.

x. As part of CMS's determination of whether or not the rate certification submission and supporting documentation adequately demonstrate that the rates were developed using generally accepted actuarial practices and principles and consistent with the regulatory requirements, CMS will consider whether the submission demonstrates the following:

(a) All adjustments to the capitation rates or to any portion of the capitation rates referenced in 42 CFR §§ 438.5(b)(4) and 438.5(f) must reflect reasonable, appropriate, and attainable costs in the actuary's judgment and must be included in the rate certification.

(b) Adjustments to the rates 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 will not be considered actuarially sound if adjustments are made outside of the rate setting process described in the rate certification.

(c) Consistent with 42 CFR §§ 438.7(c) and 438.4(c)(2)(i), the final contracted rates in each cell must match the capitation rates or, for rate ranges that are approvable under § 438.4(c), be within rate ranges in the rate certification. This is required in total and for each and every rate cell.

xi. Rates must be certified for all time periods for which they are effective, and a certification must be provided for rates for all time periods. Rates from a previous rating period cannot be used for a future time period without an actuarial certification of the rates for the new rating period.

xii. The state and its actuary should describe the evaluation conducted, and the rationale for any applicable assumptions included or not included in rate development related to the impact of the COVID-19 public health emergency and related unwinding (such as when the continuous enrollment condition ends as part of the Consolidated Appropriations Act, 2023) within the rate certification. States and their actuaries should evaluate state specific, and other applicable national or regional data that is available and applicable for determining how to address the direct and indirect impacts of the COVID-19 public health emergency in rate setting. CMS recommends all states implement a 2-sided risk mitigation strategy for rating periods impacted by the public health emergency. CMS also recommends states implement or continue 2-sided risk mitigation strategies for the period of time following the end of the public health emergency until enrollment is expected to stabilize. Please refer to the CMCS Informational Bulletin published on May 14, 2020 and COVID Frequently Asked Questions for State Medicaid and CHIP Agencies for further information regarding rate development and risk mitigation considerations around the COVID-19 public health emergency. The state must ensure that it complies with the requirements in 42 CFR § 438.6(b)(1), including that the risk mitigation strategy must be documented in the contract and rate certification documents for the rating period prior to the start of the rating period.[14]

xiii. Procedures for rate certifications for rate and contract amendments, include:

(a) If a state intends to claim FFP for capitation rates, the state must comply with the time limit for filing claims for FFP specified in section 1132 of the Act and implementing regulations at 45 CFR part 95. States should timely submit rate certifications to CMS to help mitigate timely filing concerns.

(b) If the actuary is certifying rates (and not rate ranges), the state must submit a revised rate certification when the rates change, except for changes permitted as specified in 42 CFR § 438.4(c) or 42 CFR § 438.7(c)(3).[15] In accordance with 438.4(c)(2)(ii), States that use rate ranges are not permitted to modify the capitation rates under 438.7(c)(3).[16] CMS standards for a revised rate certification if the state and its actuary determine that changes are needed within the rate range during the rate year are outlined in Section I, Item 1.A.ix.c of this rate guide.

[14] Please see footnote 7 for additional documentation requirements for risk-sharing strategies.

[15] For states that implement capitation rate adjustments that result in an increase or decrease of more than 1.5 percent from the most recently certified capitation rates for any rate cell, states will need to submit a rate amendment and contract amendment. The rate amendment must address and account for all differences from the most recently certified rates.

[16] States are permitted to either use the rate range option under 42 CFR §§ 438.4(c)(1) or use the *de minimis* rate adjustment under 438.7(c)(3), but states are not permitted to use both mechanisms in combination.

(c) For contract amendments that do not affect the rates and for rate changes permitted as specified in 42 CFR §§ 438.4(c) or 438.7(c)(3), CMS does not require a rate amendment from the state. However, if the contract amendment revises the covered populations, services furnished under the contract or other changes that could reasonably change the rate development and rates, the state and its actuary must provide supporting documentation indicating the rationale as to why the rates continue to be actuarially sound in accordance with 42 CFR § 438.4.

(d) New or revised rate certifications are not required for limited payment changes:

(i) If the actuary certified rates per rate cell (and not rate ranges), the state may increase or decrease the most recently certified actuarially sound capitation rates per rate cell, as required in 42 CFR §§ 438.7(c) and 438.4(b)(4), up to 1.5 percent during the rating period, in accordance with 42 CFR § 438.7(c)(3).[17]

(ii) If the actuary certified rate ranges for the rate cell(s), the state may increase or decrease the capitation rates per rate cell *within the certified rate range* up to 1 percent during the rating period, in accordance with 42 CFR § 438.4(c)(2).[18]

(iii) If the contract and rate certification specify an approved risk adjustment methodology (such as applying risk scores to the capitation rates paid to the managed care plan(s)), the state may apply that specified methodology to increase or decrease payment to the managed care plan(s), in accordance with 42 CFR § 438.7(b)(5)(iii). The changes to payment in this situation are within the scope of the original, approved rate certification and contract that was reviewed and approved by CMS. The State must provide to CMS the payment

[17] While a rate amendment to the actuarial certification is not required in accordance with 42 CFR § 438.7(c)(3), states must submit a contract amendment to effectuate any rate adjustment as the final capitation rates must be specifically identified in the managed care plan contracts in accordance with 42 CFR § 438.3(c) and are subject to the requirements at 42 CFR § 438.4(b)(1). CMS also expects states to provide documentation that this *de minimis* rate adjustment ensures compliance with 42 CFR § 438.3(c), 438.3(e), 438.4(b)(1) and 438.7(c)(3). States must provide documentation of the percentage change of the rate adjustment per rate cell in comparison to the most recently certified actuarially sound capitation rates and an assurance that the state has not previously utilized the flexibility outlined in 42 CFR § 438.7(c)(3) during the applicable rating period.

[18] While a rate amendment to the actuarial certification is not required when the state adjusts the capitation rates within the permissible 1 percent range in accordance with 42 CFR § 438.4(c), states must submit a contract amendment to effectuate any rate adjustment as the final capitation rates must be specifically identified in the managed care plan contracts in accordance with 42 CFR § 438.3(c)(1) and are subject to the requirements at 42 CFR § 438.4(b)(1). CMS also expects states to provide documentation ensuring compliance with 42 CFR § 438.4(b)(1) and (c). States must provide documentation of the percentage change of the rate adjustment per rate cell in comparison to the most recently contracted rates consistent with the certified actuarially sound rate ranges and an assurance that the state has not previously utilized the flexibility outlined in 42 CFR § 438.4(c) during the applicable rating period.

terms updated by the application of the risk adjustment methodology consistent with § 438.3(c).

(e) Any time a rate changes for any reason other than application of an approved payment term (e.g., 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 rate amendment.

(f) State Medicaid program features are sometimes invalidated by courts of law, or by changes in federal statutes, regulations or approvals. A state must submit a contract amendment and rate amendment to adjust capitation rates to address changes in applicable law or losses of program authority. The rate amendment must take into account the effective date of the loss of program authority. Each state's circumstances may vary and CMS is available to provide technical assistance as needed.

B. Appropriate Documentation

i. The certification must clearly indicate whether the actuary is either certifying capitation rates or capitation rate ranges.

ii. States and their actuaries must document all the elements described within their rate certification and provide adequate detail such that CMS is able to determine whether or not the regulatory standards are met. In evaluating the rate certification, CMS will look to the reasonableness of the information contained in the rate 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:

(a) data used, including citations to studies, research papers, other states' analyses, or similar secondary data sources;

(b) assumptions made, including any basis or justification for the assumption; and

(c) methods for analyzing data and developing assumptions and adjustments.

iii. If the State and its actuary develop and certify capitation rates per rate cell (and not rate ranges), the certification must disclose and support the specific assumptions that underlie the certified rates for each rate cell, including the magnitude and narrative support for each specific assumption or adjustment that underlies the certified rates for each rate cell. To the extent assumptions or adjustments underlying the capitation rates varies between managed care plans, the certification must also describe the basis for this variation.

iv. If the State and its actuary develop and certify capitation rate ranges per rate cell in accordance with 42 CFR § 438.4(c), the rate certification must include the following:

(a) A statement that both the upper and lower bounds of the rate range are being certified as actuarially sound consistent with the requirements in 42 CFR §§ 438.4 through 438.7.

(b) A table of the certified rate ranges clearly showing that the upper bound of the rate range does not exceed the lower bound of the rate range multiplied by 1.05 for each rate cell.

(c) The data, assumptions, and methodologies used to develop the upper and lower bounds of the rate range for each rate cell. This documentation should include:

(i) any assumptions (such as trend) for which values are varied in order to develop rate ranges;

(ii) the values of each of the assumptions used to develop the lower bound and the upper bounds of the rate ranges for each rate cell; and

(iii) a description of the data, assumptions, and methodologies that were used to develop the values of the assumptions for the lower bound and the upper bound of the rate ranges.

(d) The state's criteria for paying managed care plans at different points within the rate range, which must comply with the prohibition in 42 CFR § 438.4(c)(1)(v) and other applicable legal authority.[19,20]

[19] As outlined in the preamble of the 2020 Medicaid and Children's Health Insurance Program (CHIP) Managed Care Rule (85 FR 72764), "we confirm that such criteria could include state negotiations with managed care plans or a competitive bidding process, as long as states document in the rate certification how the negotiations or the competitive bidding process produced different points within the rate range. For example, if specific, documentable components of the capitation rates varied because of state negotiations or a competitive bidding process, the rate certification must document those specific variations, as well as document how those variations produced different points within the rate range, to comply with § 438.4(c)(1)(iv) and (c)(2)(i). We understand that capitation rate development necessarily involves the use of actuarial judgment, such as adjustments to base data, trend projections, etc., and that could be impacted by specific managed care plan considerations (for example, one managed care plan's utilization management policies are more aggressive versus another managed care plan's narrow networks); under this final rule, states must document such criteria as part of the rate certification to comply with § 438.4(c)(1)(iv) and (c)(2)(i)."

[20] When the state submits its rate certification for rate ranges to CMS for review, in accordance with 42 CFR § 438.4(c)(v), the state must also provide an assurance that the State does not use as a criterion for paying managed care plans at different points within the rate range any of the following: (1) the willingness or agreement of the MCOs, PIHPs, or PAHPs or their network providers to enter into, or adhere to, IGT agreements; or (B) The amount of funding the MCOs, PIHPs, or PAHPs or their network providers provide through IGT agreements. In addition, other applicable law concerning the Medicaid program or use of federal grants apply even if not specifically cited in § 438.4(c).

(e) The information related to rate range development must be included either in 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 rate certification index must identify where the information and data are described.

v. The rate certification must include an index that identifies the page number or the section number for each item described within this guidance. In cases where not all sections of this guidance are relevant for a particular rate certification (i.e., a rate amendment that adds a new benefit for part of the year), inapplicable sections of the guidance must be included and marked as "Not Applicable" in the index. CMS requires that the rate certification include an index and this index should also follow the structure of this guidance.

vi. The rate certification must include an assurance that any proposed differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations comply with 42 CFR § 438.4(b)(1), including that any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations are based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations, and that these differences do not vary with the rate of FFP associated with the covered populations in a manner that increases federal costs. States and their actuaries are reminded that 42 CFR § 438.4(b)(6) requires the actuary to certify compliance with the rate development requirements in 42 CFR Part 438, including compliance with these requirements related to differences in rates and rate development for different covered populations. CMS may require a state to provide written documentation and justification that any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations or contracts represent actual cost assumptions based on the characteristics and mix of the covered services or the covered populations. The state must have documentation to provide to CMS upon request, which may include the following information:

(a) A description of each assumption, methodology, or factor used to develop capitation rates that varies by the rate of FFP associated with all covered populations.

(b) A justification of how each difference in the assumptions, methodologies, or factors used to develop capitation rates for the covered population represents

actual cost differences based on the characteristics and mix of the covered services or the covered populations.

(c) The financial impact on federal costs of the difference in each of the assumptions, methodologies, or factors used to develop capitation rates for covered populations that varies by the rate of FFP associated with all covered populations.

vii. 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 must be separately shown as part of the rate certification to the extent possible.

viii. CMS requests that states that operated the managed care program or programs covered by the rate certification in previous rating periods provide:

(a) A comparison to the final certified rates in the previous rate certification. For the first rate certification for a rating period, this should be a comparison to the prior rating period's rates. For rate certifications that revise or amend previously certified rates for a rating period, this should be a comparison to the latest certified rates for the rating period or to the extent there has been a *de minimis* change to the rates under 42 CFR § 438.7(c)(3), this should be a comparison to the rates after the *de minimis* change. If there are large or negative changes in rates from the previous year, the actuary must describe what is leading to these differences.

(b) A description of any other material changes to the capitation rates or the rate development process compared to the prior rating period (or compared to the latest rate certification for rate certifications that amend rates) not otherwise addressed in the other sections of this guidance.

(c) A description of whether the state adjusted the actuarially sound capitation rates in the previous rating period by a *de minimis* amount using the authority in 42 CFR § 438.7(c)(3).

ix. The rate certification should include a list of known amendments that will be provided to CMS in the future, when the state expects the amendments will be submitted to CMS, and why the current certification cannot account for changes that are anticipated to be made to the rates.

x. States and actuaries must document in their rate certification the approach to address the impact of the COVID-19 public health emergency and related unwinding to ensure the rates are actuarially sound in accordance with 42 CFR § 438.4. This must include the following:

(a) A detailed description of state specific, and/or other applicable national or regional data and information (utilization, enrollment, deferred caseload, vaccinations or treatments, etc.) that is available and applicable for determining how to address the COVID-19 public health emergency and related unwinding in rate setting.

(b) A description of how the capitation rates account for the direct and indirect impacts of the COVID-19 public health emergency and related unwinding, including but not limited to changes in acuity of the covered population due to enrollment changes, changes in utilization of services, COVID-19 testing, new treatments and vaccines, deferred care, expanded coverage of telehealth, etc.

(c) A description of any COVID-19 related costs that are covered on a non-risk basis outside of the capitation rates (COVID-19 testing, vaccines, treatments, etc.).

(d) A description of any risk mitigation strategies being utilized, how the strategies in place compare to the strategies (if any) utilized in the prior rating period, and explanation for any changes.

2. Data

A. Rate Development Standards

i. In accordance with 42 CFR § 438.5(c), states and actuaries must follow rate development standards related to base data, including:

(a) States must provide all the validated encounter data and/or fee-for-service (FFS) data (as appropriate) and audited financial reports (see § 438.3(m)) that demonstrates experience for the populations to be served by the managed care plan(s) to the state's actuary developing the capitation rates for at least the three most recent and complete years prior to the rating period.

(b) States and their actuaries must use the most appropriate base data, from the three most recent and complete years prior to the rating period, for developing capitation rates.[21]

[21] The preamble of the 2016 Medicaid and CHIP Managed Care Rule provides additional context around data requirements related to 42 CFR 438.5(c)(2) per 81 FR 27573: "In § 438.5(c), we proposed standards for selection of appropriate base data. In paragraph (c)(1), we proposed that, for purposes of rate setting, states provide to the actuary Medicaid-specific data such as validated encounter data, FFS data (if applicable), and audited financial reports for the 3 most recent years completed prior to the rating period under development. In § 438.5(c)(2), we proposed that the actuary exercise professional judgment to determine which data is appropriate after examination of all data sources provided by the state, setting a minimum parameter that such data be derived from the Medicaid population or derived from a similar population and adjusted as necessary to make the utilization and cost data comparable to the Medicaid population for which the rates are being developed. We proposed that the data that the actuary uses must be from the 3 most recent years that have been completed prior to the rating period for which rates are being developed. For example, for rate setting activities in 2016 for CY 2017, the data used must at least include data from calendar year 2013 and later. We noted that while claims may not be finalized for 2015, we would expect

(c) Base data must be derived from the Medicaid population, or, if data on the Medicaid population is not available, derived from a similar population and adjusted to make the utilization and price data comparable to data from the Medicaid population.

(d) States that are unable to develop rates using data that is no older than from the three most recent and complete years prior to the rating period may request approval for an exception as follows:

(i) This request should be submitted by the state as soon as the actuary starts developing the rate certification and makes a determination that base data will not comply with 42 CFR § 438.5(c)(1)-(2).

(ii) The request must describe why an exception is necessary and describe the actions the state intends to take to come into compliance with those requirements.

(iii) The request must describe the corrective action plan for the state to come into compliance with base data standards per 42 CFR § 438.5(c) no later than two years after the last day of the rating period for which the deficiency is identified.

(iv) Given the unique nature of the COVID-19 public health emergency, CMS will streamline the exception process for this purpose. CMS recommends that in advance of submitting rate certifications to CMS, states that wish to request such an exception do so via email (to the MMCratesetting@cms.hhs.gov mailbox). CMS will review the state's request for an exception and respond regarding our decision. Below is more guidance regarding this streamlined process:

(i) With its request, the state must provide reasonable documentation explaining why the exception is necessary. For example, CMS would find reasonable documentation to be that the COVID-19 public health emergency impacted the more recent base data and the state's actuary believes it is more appropriate to utilize older base data, with appropriate adjustments, to inform rate development.

(ii) Additionally, given the unique nature of the COVID public health emergency and its impact on base data, CMS does not believe each state

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the actuary to make appropriate and reasonable judgments as to whether 2013 or 2014 data, which would be complete, must account for a greater percentage of the base data set. We used a calendar year for ease of reference in the example, but a calendar year is interchangeable with the state's contracting cycle period (for example, state fiscal year)."

must submit a corrective action plan with its request. Unless otherwise noted by a state in its request, CMS will consider the corrective action plan for all states to be that the state will come into compliance with the base data standards no later than 2 years after the last day of the rating period for which the deficiency was identified.

B. Appropriate Documentation

i. In accordance with 42 CFR § 438.7(b)(1), the rate certification must include:

(a) A description of base data requested and used for the rate setting process, including:

(i) A summary of the base data that was requested by the actuary.

(ii) A summary of the base data that was provided by the state.

(iii) An explanation of why any requested base data was not provided by the state.

ii. The rate certification, as supported by the assurances from the state, must thoroughly describe the data used to develop the capitation rates, including:

(a) A description of the data, including:

(i) the types of data used, which may include, but is not limited to: FFS claims data; managed care encounter data; managed care plan financial data; information from program integrity audits; or other Medicaid program data;

(ii) the age or time periods of all data used;

(iii) the sources of all data used (e.g., State Medicaid Agency; other state agencies; managed care plan(s); or other third parties); and

(iv) 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 plan(s) or provider(s); or, if data is not received from the subcapitated plan(s) or provider(s), a description of how the historical costs related to subcapitated arrangements were developed or verified.

(v) if an exception to base data requirements has been requested by a state and granted by CMS due to the COVID-19 public health emergency (if applicable) and the date CMS granted this exception.

(b) Information related to the availability and the quality of the data used for rate development, including:

(i) The steps taken by the actuary or by others (e.g., State Medicaid Agency; managed care plan(s); external quality review organizations; financial auditors; etc.) to validate the data, including:

(A) completeness of the data;

(B) accuracy of the data; and

(C) consistency of the data across data sources.

(ii) A summary of the actuary's assessment of the data.

(iii) Any concerns that the actuary has regarding the availability or quality of the data.

(c) A description of how the actuary determined what data was appropriate to use for the rating period, including:

(i) If FFS claims or managed care encounter data are not used (or are not available), this description should include an explanation of why the data used in rate development is appropriate for setting capitation rates for the populations and services to be covered.

(ii) If managed care encounter data was not used in the rate development, this description should include 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.

(d) 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.

iii. The rate certification, as supported by the assurances from the state, must thoroughly describe any material adjustments, and the basis for the adjustments, that are made to the data, including but not limited to adjustments for:

(a) the credibility of the data;

(b) completion factors;

(c) errors found in the data;

(d) 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

(e) exclusions of certain payments or services from the data.

3. Projected Benefit Costs and Trends

A. Rate Development Standards[22]

i. Final capitation rates must be based only upon the services allowed in 42 CFR §§ 438.3(c)(1)(ii) and 438.3(e). Therefore, if a state seeks to pay managed care plans for state-only funded services, the state must do so via separate state-only funded payment. Payments for these services may not be included in the Medicaid rate certification submitted for CMS review and approval.

ii. In accordance with 42 CFR § 438.5(d), each projected benefit cost trend assumption must be reasonable and developed in accordance with generally accepted actuarial principles and practices. Trend assumptions must be developed primarily from actual experience of the Medicaid population or from a similar population and include consideration of other factors that may affect projected benefit cost trends through the rating period.

iii. If the projected benefit costs include costs for an in lieu of service or setting (ILOS) defined at 42 CFR § 438.3(e)(2) (i.e., substitute for State plan service or setting[23]), the utilization and unit costs of the ILOS must be taken into account in developing the projected benefit costs of the covered services (as opposed to utilization and unit costs of the State plan services or settings), unless a statute or regulation explicitly requires otherwise. The costs of a short term stay in an IMD as an ILOS must not be used in rate development. See Section I, Item 3.A.iv of this guide.

iv. In accordance with the SMDL published on January 4, 2023,[24] when a managed care program includes ILOSs, with the exception of short term stays in an IMD, states must provide documentation of the projected ILOS Cost Percentage and the final ILOS Cost Percentage as well as a summary of actual managed care plan costs for delivering ILOSs. This SMDL also outlines many other requirements states must meet to obtain CMS approval for states' managed care plan contracts that include ILOS(s). States must conform with this SMDL and the below expectations outlined in this guide effective with the date of publication of the SMDL for all new ILOSs. States using existing ILOSs clearly documented in an approved managed care plan contract as of the date of publication of the SMDL will have until the contract rating

[22] The state must ensure that it complies with 42 CFR § 438.4(b)(1). Rate development standards and documentation requirements are outlined in Section I, Item.1 of this guide.

[23] As outlined in the State Medicaid Director Letter (SMDL), published on January 4, 2023 (SMD 23-001), ILOSs can be used, at the option of the managed care plan and the enrollee, as immediate or longer term substitutes for state plan-covered services or settings, or when the ILOSs can be expected to reduce or obviate the future need to utilize state plan-covered services or settings.

[24] https://www.medicaid.gov/federal-policy-guidance/downloads/smd23001.pdf

period beginning on or after January 1, 2024 to conform with the SMDL and the guidance outlined in this guide for existing ILOSs.

(a) As part of each rate certification, the State's actuary must estimate, document, and certify the projected ILOS Cost Percentage applicable to the program(s) covered under the certification that include(s) ILOS. The projected ILOS Cost Percentage is the portion of the total capitation payments attributable to all ILOSs, excluding short term stays in an IMD, for the specific managed care program (numerator) divided by the total projected dollar amount of capitation payments specific to the Medicaid managed care program that includes the ILOS (denominator), which must include all state directed payments in accordance with 42 CFR § 438.6(c) and pass-through payments in accordance with 42 CFR § 438.6(d). The projected ILOS Cost Percentage must be updated and documented with each applicable rate amendment, such as those that change the ILOSs offered, capitation rates, pass-through payments and/or state directed payments.

(b) As part of a separate actuarial report that must be submitted to CMS no later than 2 years after the completion of the contract year that includes the ILOS(s), the State's actuary must submit documentation of the final ILOS Cost Percentage applicable to each program for CMS review.[25] The final ILOS Cost Percentage is the portion of the total capitation payments attributable to all ILOSs, excluding short term stays in an IMD, for the specific managed care program (numerator) divided by the total actual dollar amount of capitation payments specific to the Medicaid managed care program that includes the ILOS (denominator), which must include all state directed payments in accordance with 42 CFR § 438.6(c) and pass-through payments in accordance with 42 CFR § 438.6(d). Additionally, this report must include a summary of the actual managed care plan costs for delivering ILOSs based on claims and encounter data provided by the managed care plans to States. This information must be certified by the State's actuary as accurate to the best of their knowledge and consistent with any applicable guidance or regulations, and provided to CMS in a separate actuarial report with the future rate certification(s) required in 42 CFR § 438.7(a) for the applicable programs that include the ILOS(s). Documentation expectations for this separate report are outlined in Appendix B.

v. When IMDs are used as an ILOS, states may make a monthly capitation payment to an MCO or PIHP under a "risk contract" (as defined in 42 CFR § 438.2; *see also* section 1903(m)(7) of the Act) for an enrollee age 21 to 64 receiving inpatient treatment in an IMD (as defined in 42 CFR § 435.1010) for a short term stay of no

[25] For example, the report for a program that uses a calendar year 2024 rating period must be submitted to CMS with the calendar year 2027 rate certification.

more than 15 days during the period of the monthly capitation payment in accordance with 42 CFR § 438.6(e). In this case, 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, as opposed to the unit costs of the IMD services. The actuary may use the utilization of the services provided to an enrollee in an IMD in developing the utilization component of projected benefit costs. The data used for developing the projected benefit costs for these services must not include:

(a) costs associated with an IMD stay of more than 15 days; and

(b) any other costs for any services delivered during the time an enrollee is in an IMD for more than 15 days.

B. Appropriate Documentation

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 managed care plan(s)).

ii. The rate certification and supporting documentation must describe the development of the projected benefit costs included in the capitation rates, including:

(a) A description of the data, assumptions, and methodologies used to develop the projected benefit costs and, in particular, all material items in developing the projected benefit costs.

(b) Any material changes to the data, assumptions, and methodologies used to develop projected benefit costs since the last rate certification must be described.

(c) The amount of recoveries of overpayments to providers and a description of how the state accounted for this in rate development. *See* § 438.608(d).

iii. The rate certification and supporting documentation must include a section on projected benefit cost trends (i.e., an estimate of the projected change in benefit costs from the historical base data period to the rating period of the rate certification) in accordance with 42 CFR § 438.7(b)(2).

(a) This section must include:

(i) Any data used or assumptions made in developing projected benefit cost trends, including a description of the sources of those data and assumptions.

(A) Citations for the data and sources used to develop the assumptions should be included whenever possible, particularly when published articles, reports, and sources other than actual experience from the Medicaid population are used.

(B) The description should state whether the trend is developed primarily with actual experience from the Medicaid population or provide rationale for the experience from a similar population that is utilized, and consideration of other factors expected to impact trend.

(ii) The methodologies used to develop projected benefit trends.

(iii) 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.

(iv) Documentation supporting the chosen trend rates and explanation of outlier and/or negative trends.

(b) This section must include the projected benefit cost trends separated into components, specifically:

(i) The projected benefit cost trends should be separated into:

(A) changes in price (i.e., pricing differences due to different provider reimbursement rates or payment models); and

(B) changes in utilization (i.e., differences in the amount, duration, or mix of benefits or services provided).

(ii) 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.

(iii) 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).

(c) Variations in the projected benefit cost trends must be explained. Projected benefit cost trends may vary by:

(i) Medicaid populations;[26]

(ii) rate cells; and

(iii) subsets of benefits within a category of services (e.g., specialty vs. non-specialty drugs).

(d) Any other material adjustments to projected benefit cost trends must be described in accordance with 42 CFR § 438.7(b)(4), including:

[26] The state must ensure that it complies with 42 CFR § 438.4(b)(1). Rate development standards and documentation requirements are outlined in Section I, Item.1 of this guide.

(i) A description of the data, assumptions, and methodologies used to determine each adjustment.

(ii) The cost impact of each material adjustment.

(iii) Where in the rate setting process the material adjustment was applied.

(e) Any other adjustments to projected benefit costs trends must be listed. CMS also requests the following detail about non-material adjustments:

(i) The impact of managed care on the utilization and the unit costs of health care services.

(ii) Changes to projected benefit costs trend in the rating period outside of regular changes in utilization or unit cost of services.

iv. If the projected benefit costs include additional services deemed by the state to be necessary to comply with the mental health parity standards in 42 CFR Part 438, subpart K[27] as required by 42 CFR § 438.3(c)(1)(ii), the following must be described:

(a) The categories of service that contain these additional services necessary for parity.

(b) The percentage of cost that these services represent in each category of service;

(c) 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.

(d) An assurance that the payment represents a payment amount that is adequate to allow the MCO, PIHP or PAHP to efficiently deliver covered services to Medicaid-eligible individuals in a manner compliant with contractual requirements.

v. For ILOSs, the following information must be provided and documented separately for each Medicaid managed care program in each rate certification:

(a) A brief description of each ILOS in the Medicaid managed care program, and whether the ILOS was provided as a benefit during the base data period.

(b) The aggregate projected ILOS Cost Percentage (based on projected enrollment or member months), including documentation of both the numerator and denominator, as well as the impact of ILOSs on rates based on materiality, as outlined below:

[27] Part 438, subpart K applies the parity standards of the Mental Health Parity and Addiction Equity Act to Medicaid managed care plans consistent with the requirements of section 1932(b) of the Act.

(i) For each ILOS that is expected to have a material impact on the rates, the actuary must provide the projected ILOS Cost Percentage specific to that ILOS, and a description of the data, assumptions, and methodologies used to develop it.

(ii) For all ILOSs that are expected to have a non-material impact on the rates, the actuary may group those ILOSs together and provide a description of why the ILOSs were not considered to have a material impact, as well as the projected ILOS Cost Percentage of all non-material ILOSs combined, and a description of the data, assumptions, and methodologies used to develop this projected ILOS Cost Percentage.

(c) A description of how the ILOSs 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 respective category of service.

(d) For inpatient psychiatric or substance use disorder services provided in an IMD setting, rate development must comply with the requirements of 42 CFR § 438.6(e) and the data and assumptions utilized should be described in the rate certification. The costs of a short term stay in an IMD as an ILOS must not be used in rate development. See Section I, Item 3.A.iv of this guide.

vi. The rate certification must describe how retrospective eligibility periods are accounted for in rate development, including but not limited to:

(a) The managed care plan's responsibility to pay for claims incurred during the retroactive eligibility period.

(b) How the claims information are included in the base data.

(c) How the enrollment or exposure information is included in the base data.

(d) How the capitation rates are adjusted to reflect the retroactive eligibility period, and the assumptions and methodologies used to develop those adjustments.

vii. 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:

(a) more or fewer Medicaid State plan benefits covered by Medicaid managed care;

(b) any recoveries of overpayments made to providers by managed care plans in accordance with 42 CFR § 438.608(d);

(c) requirements related to payments from managed care plans to any providers or class of providers;

(d) requirements or conditions of any applicable waivers; and

(e) requirements or conditions of any litigation to which the state is subjected.

viii. 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.

(a) Any change determined by the actuary to be non-material can be grouped with other non-material changes and described within the rate certification, provided that:

(i) The rate certification includes a list of all non-material adjustments used in the rate development process.

(ii) The actuary must give a description of why the changes were not considered material and how they were aggregated into a single adjustment.

(iii) The rate certification provides a description of where in the rate setting process the adjustments were applied.

(iv) The rate certification documents the aggregate cost impact of all non-material adjustments.

4. Special Contract Provisions Related to Payment[28]

A. Incentive Arrangements

i. Rate Development Standards

(a) The rate certification and supporting documentation must describe any incentives included in the contract between the state and the managed care plan(s). An incentive arrangement, as defined in 42 CFR § 438.6(a), is any payment mechanism under which a managed care plan may receive additional funds over and above the capitation rate it was paid for meeting targets specified in the contract.

(i) The rate certification must include documentation that the total payments under the incentive arrangement (i.e., capitation rate payments plus incentive payments) will not exceed 105 percent of the approved capitation payments under the contract that are attributable to the enrollees or services covered by the incentive arrangements as required in 42 CFR § 438.6(b)(2).

ii. Appropriate Documentation

[28] This rate guidance does not address all requirements for these special contract provisions. States, plans and actuaries are encouraged to review 42 CFR § 438.6 and additional guidance issued by CMS (posted on Medicaid.gov and in the HHS Guidance Portal) for more information and guidance.

(a) The rate certification must include a description of the incentive arrangement. An adequate description includes at least:

(i) The time period of the incentive arrangement (which must not be longer than the rating period).

(ii) The enrollees, services, and providers covered by the incentive arrangement.

(iii) The purpose of the incentive arrangement (e.g., specified activities, targets, performance measures, or quality-based outcomes, etc.).

(iv) Confirmation that the total payments under the incentive arrangements will not exceed 105 percent of the capitation payments.

(v) A description of any effect that each incentive arrangement has on the development of the capitation rates.

B. Withhold Arrangements

i. Rate Development Standards

(a) The rate certification and supporting documentation must describe any withhold arrangements in the contract between the state and the managed care plan(s). As defined in 42 CFR § 438.6(a), a withhold arrangement is any payment mechanism under which a portion of a capitation rate is withheld from an MCO, PIHP, or PAHP and a portion of or all of the withheld amount will be paid to the MCO, PIHP, or PAHP for meeting targets specified in the contract.

(i) The targets for a withhold arrangement are distinct from general operational requirements under the contract.

(ii) Arrangements that withhold a portion of a capitation rate for noncompliance with general operational requirements are a penalty and not a withhold arrangement.

(b) In accordance with 42 CFR § 438.6(b)(3), the capitation payment(s) minus any portion of the withhold that is not reasonably achievable must be actuarially sound.

ii. Appropriate Documentation

(a) The rate certification must include a description of the withhold arrangement. An adequate description includes at least the following:

(i) The time period of the withhold arrangement (which must not be longer than the rating period).

(ii) The enrollees, services, and providers covered by the withhold arrangement.

(iii) The purpose of the withhold arrangement (e.g., specified activities, targets, performance measures, or quality-based outcomes, etc.).

(iv) A description of the total percentage of the capitation rates being withheld through withhold arrangements.

(v) An estimate of the percentage of the withheld amount in a withhold arrangement that is not reasonably achievable and the basis for that determination, including the data, assumptions, and methodologies used to make this determination.

(vi) A description of how the total withhold arrangement, achievable or not, is reasonable and takes into consideration the managed care plan's financial operating needs accounting for the size and characteristics of the populations covered under the contract, as well as the managed care plan's capital reserves as measured by the risk-based capital level, months of claims reserve, or other appropriate measure of reserves.

(vii) A description of any effect that each withhold arrangement has on the development of the capitation rates.

(b) The actuary must certify capitation payment(s) minus any portion of the withhold that is not reasonably achievable as actuarially sound.

C. Risk-Sharing Mechanisms

i. Rate Development Standards

(a) In accordance with 42 CFR § 438.6(b), if the state utilizes risk-sharing mechanisms with its managed care plan(s)[29] these arrangements must be documented in the contract(s) and rate certification documents for the rating period prior to the start of the rating period,[30] and must be developed in accordance with § 438.4, the rate development standards in § 438.5, and generally accepted actuarial principles and practices. Risk-sharing mechanisms may not be added or modified after the start of the rating period.

[29] As used in section 438.6(b)(1), "risk sharing mechanisms" includes any and all mechanisms or arrangements that have the effect of sharing risk between the MCO, PIHP or PAHP and the state on an aggregate level; these include risk mitigation strategies and other arrangements that protect the state or the MCO, PIHP, or PAHP against the risk that the assumptions used in the initial development of capitation rates differ from actual experience. Common risk mitigation strategies include reinsurance, risk corridors, stop-loss limits, a medical loss ratio (MLR) with a remittance, or a risk-based reconciliation payment. 2020 Final Medicaid and Children's Health Insurance Program (CHIP) Managed Care Rule published in the Federal Register on November 13, 2020 (CMS-2408-F) (85 FR 72754, 72774)

[30] Please see footnote 7 for additional documentation requirements for risk-sharing strategies.

(b) The rate certification and supporting documentation must describe all risk-sharing mechanisms and indicate if the arrangements affect the rates or the final net payments to the managed care plan(s) under the applicable contract.

ii. Appropriate Documentation

(a) The rate certification and supporting documentation must include a description of any risk-sharing arrangements. An adequate description of each arrangement includes at least the following:

(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.

(iv) Documentation demonstrating that the risk-sharing mechanism has been developed in accordance with generally accepted actuarial principles and practices.

(v) Documentation demonstrating that the risk-sharing arrangement is consistent with pricing assumptions used in capitation rate development.

(vi) Documentation demonstrating that the risk-sharing arrangement will not result in a remittance/payment if calculated based on pricing assumptions used in capitation rate development.

(b) If the contract includes a remittance/payment requirement for being below/above a specified medical loss ratio (MLR), the rate certification and supporting documentation must also include the following:

(i) The methodology used to calculate the medical loss ratio.

(ii) The formula for calculating a remittance/payment for having a medical loss ratio below/above the requirements.

(iii) Any other consequences for a remittance/payment for a medical loss ratio below/above the requirements.

(c) If the contract has reinsurance requirements, the rate certification and supporting document must also include the following:

(i) A detailed description of any reinsurance requirements under the contract associated with the rate certification, including the reinsurance premiums and any relevant historical reinsurance experience.

(ii) Identification of any effect that the reinsurance requirements have on the development of the capitation rates.

(iii) Documentation that the reinsurance mechanism has been developed in accordance with generally accepted actuarial principles and practices.

(iv) If the actuary develops the reinsurance premiums, a description of how the reinsurance premiums were developed, including the data, assumptions and methodology used.

D. State Directed Payments

i. Rate Development Standards

(a) Consistent with 42 CFR § 438.6(c), states may utilize delivery system and provider payment initiatives (i.e., state directed payments), including requiring managed care plans to:[31]

(i) implement value-based purchasing models for provider reimbursement, such as pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services;

(ii) participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative;

(iii) adopt a minimum fee schedule for network providers that provide a particular service under the contract using Medicaid State plan approved rates;

(iv) adopt a minimum fee schedule for network providers that provide a particular service under the contract using rates other than the Medicaid State plan approved rates;

(v) provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract; and

(vi) adopt a maximum fee schedule for network providers that provide a particular service under the contract, so long as the managed care plan retains

[31] All state directed payments in Medicaid managed care contracts that are authorized under 42 CFR § 438.6(c) must be based on the utilization and delivery of services to Medicaid beneficiaries covered under the contract. These payments must be directed equally, and using the same terms of performance across a class of providers. Further details on these payments are described in § 438.6(c) and the CMCS Informational Bulletin, dated November 2, 2017: https://www.medicaid.gov/federal-policy-guidance/downloads/cib11022017.pdf. Payments permitted under 42 CFR § 438.6(d) must be addressed as noted in section E.

the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

(b) In accordance with 42 CFR § 438.6(c)(2), all state directed payments, except for minimum fee schedules using Medicaid State plan approved rates as defined in 42 CFR § 438.6(a), must receive written prior approval from CMS. Review of rate certification(s) and related contract actions that incorporate these state directed payments cannot be finalized until all necessary written prior approvals are obtained. The state directed payment(s) included in the rate certification must be consistent with the information in the approved preprint and related preprint review documents in order for CMS to review and evaluate the state directed payment and the associated capitation rates and rate certification for approval under §§ 438.4 through 438.7. Failure to ensure consistency between the approved preprints and the rate certification will impact CMS' ability to finalize our review of the rate certification.

(c) All contract arrangements that direct MCO's, PIHP's, or PAHP's expenditures must be developed in accordance with 42 CFR § 438.4, the standards specified in § 438.5, and generally accepted actuarial principles and practices. [32]

(d) The state's rate certification for the applicable period must address how each state directed payment arrangement under 42 CFR § 438.6(c) is reflected in the payments to the managed care plan from the state in accordance with § 438.7(b)(6) in order to comply with the requirement that the rate certification include a description of any special contract provision related to payment described in § 438.6; in addition, CMS requires the information specified here in order to evaluate compliance of the state directed payment under § 438.6(c) and the rates as a whole under §§ 438.4 through 438.7. State directed payments can be incorporated into the base capitation rates as an adjustment as defined in § 438.5(f) or addressed through a separate payment term. The method by which a state incorporates a state directed payment into a related rate certification(s) will be identified and documented as part of the preprint review process. To comply with 42 CFR §§ 438.7(b)(6) and 438.7(d), when the approved state directed payment preprint and related review documents indicate that the state directed payment will be incorporated through a separate payment term, the state:

(i) must include documentation related to the payment term in the initial rate certification as outlined in Section I, Item 4.D.ii.a.iii of the guide;

[32] While some state directed payments do not require written approval prior to implementation, all state directed payments must meet the standards in 42 CFR § 438.6(c)(2)(ii)(A) through (F) and be documented in the rate certifications and states' contracts with its managed care plans.

(ii) must include in the initial rate certification documentation an estimate of the magnitude of that portion of the payment on a PMPM basis for each rate cell (CMS recognizes that this is an estimate); and

(iii) after the rating period is complete and the state makes the payment consistent with the contract and as reflected in the initial rate certification, the state should submit documentation to CMS that incorporates the total amount of the payment into the rate certification's rate cells consistent with the distribution methodology included in the approved state directed payment preprint, as if the payment information (e.g., providers receiving the payment, amount of the payment, utilization that occurred, enrollees seen, etc.) had been known when the rates were initially developed.

(iv) Additionally, please note, if the total amount of the payment or distribution methodology is changed from the initial rate certification, CMS expects the state to submit a rate amendment for the rating period, and clearly describe both the magnitude of and the reason for the change.

(e) In accordance with 42 CFR §§ 438.6(b)(1) and 438.7(b)(6), all state directed payments must be documented in the rate certification. Therefore, the state cannot utilize the *de minimis* flexibility outlined in 42 CFR §§ 438.4(c)(2)(ii) and 438.7(c)(3) for changes to these payment arrangements. A state must submit a rate amendment for any new or revised state directed payment arrangement not included in the initial rate certification in accordance with 42 CFR §§ 438.4(c)(2)(iii)(C) and 438.7(c)(2).

ii. Appropriate Documentation

(a) To comply with 42 CFR §§ 438.7(b)(6) and 438.6(c), the rate certification and supporting documentation must include a description of each state directed payment utilized by the state within the applicable Medicaid managed care program(s), including those that do not require prior approval in accordance with 42 CFR § 438.6(c). The specific description and additional documentation needed depends on which approach the state has used to incorporate the payment into its rate certification. In addition to the information provided in the body of the certification, the state must provide the following information for each state directed payment, including those that do not require prior approval, in the table format outlined below (please include this information for each applicable state directed payment in a separate row):

Control name of the state directed payment[33]	Type of payment (see (i)(A) below)	Brief description (see (i)(B) below)	Is the payment included as a rate adjustment or separate payment term? (see (ii) and (iii) below)
A			
B			
C			

(i) A brief description of the state directed payment, including the following:

(A) The type of state directed payment (minimum fee schedule, maximum fee schedule, bundled payment, etc.).

(B) A brief description (e.g., minimum fee schedule is set at $x as approved in the Medicaid State plan, minimum fee schedule is set at y % of Medicare, etc.).

(ii) To comply with 42 CFR §§ 438.7(b)(6) and 438.6(d), if the state directed payment will be incorporated into the rate certification in the base capitation rates as a rate adjustment consistent with the approved preprint and related preprint review documentation, then in addition to the information provided in the body of the certification, the following information must be included in the state's rate certification in the table format (please include this information for each applicable state directed payment in a separate row, including those that do not require prior approval):

Control name of the state directed payment[34]	Rate cells affected (see (A) below)	Impact (see (B) below)	Description of the adjustment (see (C) below)	Confirmation the rates are consistent with the preprint (see (D) below)	For maximum fee schedules, provide the information requested in (E) below
A					
B					
C					

[33] If the state directed payment does not require written approval prior to implementation per 42 CFR § 438.6(c)(2)(ii), and thus does not have a CMS issued control name, the state should provide a name for the state directed payment that clearly describes the arrangement for tracking and organizational purposes.

[34] See prior footnote.

(A) An indication of each rate cell affected by the state directed payment.

(B) A clear reference to the specific exhibit that shows the impact of the state directed payment has on the rates, for each rate cell. Each state directed payment rate adjustment must be separately identified in the exhibit; the exhibit cannot combine the impacts of state directed payments.

(C) A description of how the state directed payment is reflected in the certified capitation rates. To the extent an adjustment is applied in rate development to account for the impact of the state directed payment, or changes to the state directed payment from the base data period, the actuary should provide a description of the data, assumptions, and methodologies used to develop the adjustment.

(D) An indication that the actuary has received and reviewed each state directed payment preprint at the time the rates were certified and that each state directed payment included in the rates is consistent with the preprint (including any correspondence between the state and CMS regarding the pre-print) reviewed and approved by CMS, when prior approval is required per 42 CFR § 438.6(c)(2)(ii). To the extent the state directed payment preprint has not been approved by CMS before the actuary certifies the capitation rates, this should be noted in the certification, and the state directed payment that is under review should still be accounted for in rate development. In this case, the actuary should also provide an indication that the state directed payment is accounted for in a manner consistent with the pre-print that is under CMS review. If the state directed payment preprint has not yet been submitted to CMS for review, the certification should provide a specific timeline for when the preprint will be submitted to CMS.

(E) If implementing a maximum fee schedule, the actuary should explain if there are any instances in the base data where the managed care plan(s) paid above the maximum fee schedule and how the actuary determined that it was reasonable to assume that the managed care plan(s) that currently pay above the maximum fee schedule will be able to lower their reimbursement rates consistent with the maximum fee schedule requirement. The actuary should also explain whether there are any exemptions to the maximum fee schedule which allow for managed care plan(s) to pay above the maximum fee schedule

during the rating period and how these exemptions were considered in rate development.

(iii) If the state directed payment will be incorporated into the initial rate certification as a separate payment term consistent with the approved preprint and related preprint review documentation, then in addition to the information provided in the body of the certification, the following information must be included in the state's rate certification in the following format (please include this information for each applicable state directed payment in a separate row, including those that do not require prior approval):

Control name of the state directed payment[35]	**Aggregate amount included in the certification (see (A) below)**	**Statement that the actuary is certifying the separate payment term (see (B) below)**	**The magnitude on a PMPM basis (see (C) below)**	**Confirmation the rate development is consistent with the preprint (see (D) below)**	**Confirmation that the state and actuary will submit required documentation at the end of the rating period (as applicable; see (E) below)**
A					
B					
C					

(A) The aggregate amount of the payment applicable to the rate certification. If the separate payment term directed payment is paid and certified as a part of the capitation rate on a PMPM basis, provide the estimated aggregate amount of the payment.

(B) An explicit statement from the actuary that he or she certifies the amount of the separate payment term disclosed in the certification (i.e., the amount in Section I, Item 4.D.ii.a.iii.A).

(C) A clear reference to the specific exhibit that shows an estimate of the magnitude of the state directed payment on a PMPM basis for each rate cell (CMS recognizes that this is an estimate for separate payment terms that are incorporated as pools). If the state directed payment, addressed as a separate payment term, is paid and certified as a part of the capitation rate on a PMPM basis, provide the amount of the

[35] See prior footnote.

payment on a PMPM basis. Each separate payment term must be separately identified in the exhibit; the exhibit cannot combine the impacts of state directed payments.

(D) An indication that the state directed payment is consistent with the pre-print (including correspondence between the state and CMS regarding the pre-print) reviewed and approved by CMS, when prior approval is required per 42 CFR § 438.6(c)(2)(ii). To the extent the state directed payment preprint has not been approved by CMS before the actuary certifies the capitation rates, this should be noted in the certification and the state directed payment that is under review should still be accounted for in rate development. In this case, the actuary should also provide an indication that the state directed payment is accounted for in a manner consistent with the pre-print that is under CMS review. If the preprint has not been submitted to CMS for review, the certification should provide a specific timeline for when the preprint will be submitted to CMS.

(E) A statement that after the rating period is complete, the state will submit to CMS documentation that incorporates the total amount of the state directed payment into the rate certification's rate cells consistent with the distribution methodology included in the approved state directed payment preprint, and as if the payment information (e.g., providers receiving the payment, amount of the payment, utilization that occurred, enrollees seen, etc.) had been fully known when the rates were initially developed. Note this is only applicable to separate payment terms that are included in the certification as separate pools that are certified in addition to the base PMPM capitation rates.

(b) The rate certification and supporting documentation must confirm that there are no additional directed payments in the program that are not addressed in the certification including minimum fee schedules using Medicaid State plan approved rates as defined in 42 CFR § 438.6(a).

(c) The rate certification and supporting documentation must confirm that there are no requirements regarding the reimbursement rates the managed care plan(s) must pay to any providers unless specifically specified in the certification as a state directed payment or authorized under applicable law, regulation, or waiver.

E. Pass-Through Payments

i. Rate Development Standards

(a) A pass-through payment, as defined in 42 CFR § 438.6(a), is any amount required by the state to be added to the contracted payment rates, and considered in calculating the actuarially sound capitation rate, between MCOs, PIHPs, or PAHPs and hospitals, physicians, or nursing facilities that is not for one of the following purposes:[36,37, 38]

(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;

(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) Pass-through payments for hospitals are allowed for a transition period as outlined in 42 CFR § 438.6(d). In order to use a transition period, unless permissible in accordance with § 438.6(d)(6),[39] a state must demonstrate that it had pass-through payments for hospitals as defined in 42 CFR § 438.6(d)(1)(i), in:[40]

(i) managed care contract(s) and rate certification(s) for the rating period that includes July 5, 2016, and were submitted for CMS review and approval on or before July 5, 2016; or

(ii) if the managed care contract(s) and rate certification(s) for the rating period that includes July 5, 2016 had not been submitted to CMS on or before July 5, 2016, the managed care contract(s) and rate certification(s) for a rating period

[36] States may not require managed care plans to make pass-through payments other than those permitted to network providers that are hospitals, physicians, and nursing facilities in accordance with 42 CFR § 438.6(d)(1).
[37] Pass-through payments are most easily identified as required payments that are not directly tied to utilization or outcomes based on utilization during the rating period of the contract.
[38] In accordance with 42 CFR § 438.6(d)(5), for rating periods beginning on or after July 1, 2022, states cannot require pass-through payments for physicians or nursing facilities. Pass-through payments for physicians and nursing facilities are no longer allowed as the transition period has ended. The only exception relates to states initially transitioning services or populations from a FFS delivery system to a managed care delivery system. See 42 CFR § 438.6(d)(6) for further details.
[39] Pass-through payments to network providers that are hospitals, nursing facilities, or physicians are allowable for the transition period identified in 42 CFR § 438.6(d)(6) for states transitioning services and populations from a FFS delivery system to a managed care delivery system when the state meets the requirements in 42 CFR 438.6(d)(6).
[40] In accordance with 42 CFR § 438.6(d)(1)(ii), CMS will not approve a retroactive adjustment or amendment, notwithstanding the adjustments to the base amount permitted in 42 CFR § 438.6(d)(2), to managed care contract(s) and rate certification(s) to add new pass-through payments or increase existing pass-through payments.

before July 5, 2016 that had been most recently submitted for CMS review and approval as of July 5, 2016.

(c) Pass-through payments to hospitals must comply with the requirements of 42 CFR § 438.6(d).

(i) In accordance with 42 CFR § 438.6(d)(3), the aggregate pass-through payments to hospitals may not exceed the lesser of: (1) 40 percent of the base amount; or (2) the total dollar amount of pass-through payments to hospitals identified in the managed care contract(s) and rate certification(s) used to meet the requirement of 42 CFR § 438.6(d)(1)(i).

(ii) In accordance with 42 CFR § 438.6(d)(5), for rating periods beginning on or after July 1, 2022, states cannot require pass-through payments for physicians or nursing facilities as the transition period has ended. The only exception is outlined below in (c)(iii) as it relates to states initially transitioning services or populations from a FFS delivery system to a managed care delivery system. See 42 CFR § 438.6(d)(6) for further details.

(iii) In accordance with 42 CFR § 438.6(d)(6), for states transitioning services or populations from a FFS delivery system to a managed care delivery system, the aggregate amount of the pass-through payments the State requires the MCO, PIHP or PAHP to make to hospitals, nursing facilities or physicians is less than or equal to the amounts calculated in 42 CFR § 438.6(d)(6)(iii)(A), (B), or (C).[41]

(A) In determining the amount of each component for the calculations contained in 42 CFR § 438.6(d)(6)(iii)(A) through (C), the State must use the amounts paid for services during the 12-month period immediately 2 years prior to the first rating period of the transition period.

(d) The base amount, as defined in 42 CFR § 438.6(d)(2) is used when determining the allowable amount of pass-through payments for hospitals, and is calculated as the sum of (i) and (ii) below:

(i) For inpatient and outpatient hospital services that will be provided to eligible populations through the MCO, PIHP, or PAHP contracts for the rating period that includes pass-through payments and that were provided to the eligible populations under MCO, PIHP, or PAHP contracts two years prior to the rating period, the state must determine reasonable estimates of the aggregate difference between:

[41] This requirement is effective for rating periods beginning on or after July 1, 2021 in accordance with the 2020 Final Medicaid and Children's Health Insurance Program (CHIP) Managed Care Rule published in the Federal Register on November 13, 2020 (CMS-2408-F) (85 FR 72754).

(A) the amount Medicare FFS would have paid for those inpatient and outpatient hospital services utilized by the eligible populations under the MCO, PIHP, or PAHP contracts for the 12-month period immediately two years prior to the rating period that will include pass-through payments; and

(B) the amount the MCOs, PIHPs, or PAHPs paid (not including pass-through payments) for those inpatient and outpatient hospital services utilized by the eligible populations under MCO, PIHP, or PAHP contracts for the 12-month period immediately 2 years prior to the rating period that will include pass-through payments.

(ii) For inpatient and outpatient hospital services that will be provided to eligible populations through the MCO, PIHP, or PAHP contracts for the rating period that includes pass-through payments and that were provided to the eligible populations under Medicaid FFS for the 12-month period immediately 2 years prior to the rating period, the state must determine reasonable estimates of the aggregate difference between:

(A) the amount Medicare FFS would have paid for those inpatient and outpatient hospital services utilized by the eligible populations under Medicaid FFS for the 12-month period immediately 2 years prior to the rating period that will include pass-through payments; and

(B) the amount the state paid under Medicaid FFS (not including pass-through payments) for those inpatient and outpatient hospital services utilized by the eligible populations for the 12- month period immediately 2 years prior to the rating period that will include pass-through payments.

(e) In accordance with 42 CFR § 438.6(d)(2)(iii), the base amount must be calculated on an annual basis and is recalculated annually.

(f) The impact of any § 438.6(c) directed payments made to hospitals during the 12-month period immediately 2 years prior to the rating period should be included when calculating amounts in accordance with 42 CFR § 438.6(d)(2)(i)(B).

(g) In accordance with 42 CFR § 438.6(d)(2)(iv), states may calculate reasonable estimates of the aggregate differences in § 438.6(d)(2)(i) and (ii) in accordance with the upper payment limit requirements in 42 CFR part 447.

(i) If the state chooses to utilize a trend adjustment when calculating reasonable estimates of the aggregate differences in § 438.6(d)(2)(i) and (ii), it must provide a justification of why an adjustment is reasonable and appropriate,

and the state should utilize the same data source for the trend adjustments when calculating amounts in § 438.6(d)(2)(i)(A), (i)(B), (ii)(A) and (ii)(B).

(ii) If the base amount calculation is using a time period during the COVID-19 public health emergency, the state at its option may choose to utilize adjustments to ensure there are reasonable estimates, such as an adjustment for trend, a volume adjustment to the encounter experience to account for the COVID-19 public health emergency on base period utilization, or other reasonable adjustments. The state must provide a justification for why the adjustment(s) are reasonable and appropriate.

(h) Capitation rates may only include pass-through payments to hospitals when permitted by 42 CFR § 438.6(d). There are only very limited circumstances, outlined in 42 CFR § 438.6(d)(6), where capitation rates are allowed to include pass-through payments for physicians and nursing facilities when states are initially transitioning services or populations from a FFS delivery system to a managed care delivery system. States may not include pass-through payments to providers other than hospitals, physicians, and nursing facilities in the capitation rates.

(i) If a state chooses to include a pass-through payment as a per member per month (PMPM) amount, tied to enrollment, the state must monitor the actual pass-through payment amounts paid during the rating period to ensure it does not exceed the amount permitted under 42 CFR § 438.6(d) to ensure compliance with the regulation. If the actual enrollment were to vary in a way that increases the pass-through payments beyond the allowable amount, the state must amend the rates to comply with Federal requirements. Additionally, the state must include the maximum dollar amount of pass-through payment amounts permitted under 42 CFR § 438.6(d) within its contracts with managed care plan(s).

ii. Appropriate Documentation

(a) The rate certification and supporting documentation must include a description of each existing pass-through payment incorporated into the rates for this rating period. An adequate description includes at least the following for *each* pass-through payment:

(i) A description of the pass-through payment, including the provider type (e.g., hospital).

(ii) A description of how the pass-through payment will be paid (e.g. an aggregate payment or a PMPM amount where the final aggregate payment varies based on actual enrollment).

(iii) The amount of the pass-through payment, both in total and on a per member per month basis (if applicable).

(iv) The program(s) that includes the pass-through payment.

(v) The providers receiving the pass-through payment.

(vi) The financing mechanism for the pass-through payment including the following:[42]

(A) A description of the non-federal share of the pass-through payment, including the source of the non-Federal share and the amount of the non-federal share financing. For example, the funds for the non-federal share may be from state legislative appropriations to the Medicaid agency, intergovernmental transfers (from a state or local government entity), provider taxes, or some other mechanism used by the state to provide the non-Federal share.

(B) For any payment funded by intergovernmental transfers, the description should include the following:

1. A complete list of the names of entities transferring funds.
2. The operational nature of the entity (state, county, city, other).
3. The total amounts transferred by each entity.
4. Clarification on whether the transferring entity has general taxing authority.
5. Clarification on whether the transferring entity received appropriations (identify level of appropriations).
6. Additional information or documentation regarding any written agreements that exist between the state and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement, including a description of any additional written agreements the state is aware may exist with healthcare providers to support and finance the non-federal share of the payment arrangement.

(C) Identification of any 42 CFR § 438.6(c) state directed payment(s) which target the same providers receiving the pass-through payment.

[42] States must use permissible funding sources that comply with all federal statute and regulations, including section 1903(w) of the Act and 42 CFR Part 433 subpart B, to fund the non-federal share of pass-through payments.

(b) The rate certification and supporting documentation must include a description of the aggregate pass-through payments incorporated into the rates for this rating period by provider type. An adequate description includes at least the following for the pass-through payments by provider type:

(i) The amount of pass-through payments by provider type both in total and on a per member per month basis (if applicable).

(ii) Documentation of historical pass-through payments by provider type that are a prerequisite for authorization to use a transition period (as outlined in 42 CFR § 438.6(d)(1)(i)), unless permissible in accordance with § 438.6(d)(6):

(A) If the managed care contract(s) and rate certification(s) for the rating period that includes July 5, 2016 were submitted to CMS on or before July 5, 2016, please provide:

1. The total aggregate amount of pass-through payments per provider type (i.e., hospital) incorporated into capitation rates for the rating period in effect on July 5, 2016.

2. The date(s) the managed care contract(s) and rate certification(s) were submitted to CMS for review and approval.

(B) If the managed care contract(s) and rate certification(s) for the rating period that includes July 5, 2016 had not been submitted to CMS on or before July 5, 2016, please provide:

1. The total aggregate amount of pass-through payments by provider type incorporated into capitation rates for the rating period before July 5, 2016 that had been most recently submitted for CMS review and approval as of July 5, 2016.

2. The date(s) the managed care contract(s) and rate certification(s) were submitted to CMS for review and approval.

(iii) In accordance with 42 CFR § 438.6(d)(6), for states transitioning services or populations from a FFS delivery system to a managed care delivery system, please provide:

(A) Confirmation that services will be covered for the first time under a managed care contract and were previously provided in a FFS delivery system prior to the first rating period of the transition period.

(B) Confirmation that the state made supplemental payments, as defined in 42 CFR § 438.6 (a), to hospitals, nursing facilities, or physicians during the

12-month period immediately 2 years prior to the first year of the transition period.

(c) In accordance with 42 CFR § 438.6(d)(4), the certification must document the following information about the base amount for hospital pass-through payments:

(i) The data, methodologies, and assumptions used to calculate the base amount, including the data, methodologies and assumptions for any reasonable estimate(s) utilized.

(A) The description must include a summary of any adjustment made to the base data used to calculate amounts in accordance with 42 CFR § 438.6(d)(2)(i)(A), (i)(B), (ii)(A) and (ii)(B), including a rationale and fiscal impact of each adjustment.

(B) An explanation of any changes to the methodology utilized for the base amount calculation from the previous years' calculations including a rationale and the fiscal impact of the proposed methodology changes.

(C) A description and justification explaining any adjustment made to the base amount calculation related to the COVID-19 public health emergency, such as an adjustment for trend, a volume adjustment to encounter experience, or any other adjustments made.

(ii) The aggregate amounts calculated for each amount in accordance with 42 CFR § 438.6(d)(2)(i)(A), (i)(B), (ii)(A) and (ii)(B).

(iii) If the state chooses to utilize trend adjustments when calculating the amounts identified in accordance with 42 CFR § 438.6(d)(2)(i)(A), (i)(B), (ii)(A) and (ii)(B), the state must ensure clear documentation, including:

(A) Explanation of the purpose of the trend adjustment (e.g., cost inflation, utilization, etc.) and justification of why an adjustment is reasonable and appropriate.

(B) The trend adjustment applied to amounts, as applicable, in accordance with 42 CFR § 438.6(d)(2)(i)(A), (i)(B), (ii)(A) and (ii)(B).

(C) A description of the data source, assumptions, and methodology used to determine each adjustment.

(D) The fiscal impact of each trend adjustment.

(E) If the state does not utilize a consistent data source for the trend adjustment used in the base amount calculation and demonstrations of upper payment limits requirements for inpatient and outpatient hospital

services in accordance with 42 CFR 447, the state must provide a clear rationale of why a different data source is reasonable and appropriate for the trend adjustments used in the base amount calculation.

(F) A description of any adjustments made due to the COVID-19 public health emergency along with a rationale and justification.

(iv) The calculation of the applicable percentage of the base amount available for pass-through payments under the schedule in accordance with 42 CFR § 438.6(d)(3).

(v) The amount of any § 438.6(c) state directed payment(s) made to hospitals during the 12-month period immediately 2 years prior to the rating period, and an explanation of how these were included in the calculations of amounts in accordance with 42 CFR § 438.6(d)(2)(i)(B).

(d) In accordance with 42 CFR § 438.6(d)(6), the certification must document the calculations in 42 CFR § 438.6(d)(6)(iii)(A), (B), or (C) for states transitioning services or populations from a FFS delivery system to a managed care delivery system, including the data, methodologies and assumptions used to develop these calculations.

5. Projected Non-Benefit Costs

A. Rate Development Standards[43]

i. In accordance with 42 CFR § 438.5(e), the development of the non-benefit component of the rate must include reasonable, appropriate, and attainable expenses related to MCO, PIHP or PAHP administration, taxes, licensing and regulatory fees, contribution to reserves, risk margin, and cost of capital. In addition, the non-benefit component must include other operational costs associated with the provision of services under the contract, including those administrative costs for compliance with the mental health parity standards in 42 CFR § 438.3, subpart K.

ii. 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.

B. Appropriate Documentation

[43] The state must ensure that it complies with 42 CFR § 438.4(b)(1). Rate development standards and documentation requirements are outlined in Section I, Item.1 of this guide.

i. The rate certification and supporting documentation must describe the development of the projected non-benefit costs included in the capitation rates in enough detail so CMS or an actuary applying generally accepted actuarial principles and practices can identify each type of non-benefit expense that is included in the rate and evaluate the reasonableness of the cost assumptions underlying each expense in accordance with 42 CFR § 438.7(b)(3). To meet this standard, the documentation must include:

(a) A description of the data, assumptions, and methodologies used to develop the projected non-benefit costs, and in particular, all material items in developing the projected non-benefit costs.

(b) Any material changes to the data, assumptions, and methodologies used to develop projected non-benefit costs since the last rate certification.

(c) Any other material adjustments must be described in accordance with 42 CFR § 438.7(b)(4), including:

(i) A description of the data, assumptions, and methodologies used to determine each adjustment.

(ii) Where in the rate setting process each adjustment was applied.

(iii) The cost impact of each material adjustment.

ii. States and actuaries should estimate the projected non-benefit costs for each of the following categories of costs:

(a) administrative costs;

(b) taxes, licensing and regulatory fees, and other assessments and fees;

(c) contribution to reserves, risk margin, and cost of capital; and

(d) other operational costs associated with the provision of services identified in § 438.3(c)(1)(ii) to the populations covered under the contract.

iii. Actuaries should disclose historical non-benefit cost data in the certification to the extent this information was provided by the managed care plan(s), and explain how the historical non-benefit cost data was considered in the non-benefit cost assumptions used in rate development.

6. Risk Adjustment

A. Rate Development Standards

i. Risk adjustment is a methodology to account for the health status of enrollees via relative risk factors when predicting or explaining costs of services covered under the

contract for defined populations or for evaluating retrospectively the experience of MCOs, PIHPs, or PAHPs contracted with the state.

ii. As required by 42 CFR § 438.5(g), if risk adjustment is applied prospectively or retrospectively, states and their actuaries must select a risk adjustment methodology that uses generally accepted models and must apply it in a budget neutral manner, consistent with generally accepted actuarial principles and practices, across all MCOs, PIHPs or PAHPs in the program to calculate adjustments to the payments as necessary.

B. Appropriate Documentation

i. In accordance with 42 CFR § 438.7(b)(5)(i), the rate certification must describe all prospective risk adjustment methodologies, including:

(a) The data, and any adjustments to that data, to be used to calculate the adjustment.

(b) The model, and any adjustments to that model, to be used to calculate the adjustment.

(c) The method for calculating the relative risk factors and the reasonableness and appropriateness of the method in measuring the risk factors of the respective populations.

(d) The magnitude of the adjustment on the capitation rate per MCO, PIHP, or PAHP.

(e) An assessment of the predictive value of the methodology compared to prior rating periods.

(f) Any concerns the actuary has with the risk adjustment process.

ii. In accordance with 42 CFR § 438.7(b)(5)(ii), the rate certification must describe all retrospective risk adjustment methodologies, including:

(a) The party calculating the risk adjustment.

(b) The data, and any adjustments to that data, to be used to calculate the adjustment.

(c) The model, and any adjustments to that model, to be used to calculate the adjustment.

(d) The timing and frequency of the application of the risk adjustment.

(e) Any concerns the actuary has with the risk adjustment process.

iii. The rate certification and supporting documentation must also specifically include:

(a) Any changes that are made to risk adjustment models since the last rating period.

(b) Documentation that the risk adjustment model is budget neutral in accordance with 42 CFR § 438.5(g).

7. **Acuity Adjustments**

A. Rate Development Standards

i. An adjustment applied to the total payments across all managed care plans to account for significant uncertainty about the health status or risk of a population is considered an acuity adjustment, which is a permissible adjustment under 42 CFR § 438.5(f) (81 FR 27595).

(a) Acuity adjustments may be used prospectively or retrospectively.

(b) While retrospective acuity adjustments may be permissible, they are intended solely as a mechanism to account for differences between assumed and actual health status when there is significant uncertainty about the health status or risk of a population, such as: (1) new populations coming into the Medicaid program; (2) a Medicaid population that is moving from FFS to managed care when enrollment is voluntary and there may be concerns about adverse selection; or (3) unwinding of the COVID-19 public health emergency (such as the the resumption of Medicaid eligibility determinations when the continuous enrollment condition ends as part of the Consolidated Appropriations Act, 2023). In the latter case, there may be significant uncertainty about the health status of which individuals would remain in FFS versus move to managed care; although this uncertainty is expected to decrease as the program matures.

(i) If the actuary is certifying rates (not rate ranges), and a retrospective acuity adjustment results in revisions to the capitation rates, the state must submit a rate amendment for review that includes all documentation requirements described in Section I, Item 1.A.xiii and B of this guide. Additionally, the rate amendment must include the final capitation rates with the acuity adjustment applied. The only exception to this requirement is if the state chooses to utilize the *de minimis* flexibility in accordance with 42 CFR § 438.7(c)(3) (see Section I, Item 1.A.xiii.b of this guide for further details).

(ii) In the case that the actuary is certifying rate ranges, CMS recommends that the state and its actuary explore whether a retrospective acuity adjustment is appropriate and feasible given federal requirements. When the actuary is certifying rate ranges, if a retrospective acuity adjustment results in revisions to the capitation rates, the state must utilize the *de minimis* flexibility in accordance with 42 CFR § 438.4(c)(2)(ii)-(iii). The state does not have the option to utilize a rate amendment as it does not meet the criteria required in

42 CFR § 438.4(c)(2)(iii)(A)-(C). For further details see Section I, Item 1.A of this guide for further details).

B. Appropriate Documentation

i. If an acuity adjustment is being used, the rate certification must include a description of the acuity adjustment and its basis that is adequate to evaluate its reasonableness and whether it is consistent with generally accepted actuarial principles and practices. Such a description includes at least:

(a) The reason that there is significant uncertainty about the health status of the population and the need for an acuity adjustment.

(b) The acuity adjustment model(s) being used to calculate acuity adjustment scores.

(c) The specific data, including the source(s) of the data, being used by the acuity adjustment model(s).

(d) The relationship and potential interactions between the acuity adjustment.

(e) How frequently the acuity adjustment scores are calculated.

(f) A description of how the acuity adjustment scores are being used to adjust the capitation rates.

(g) Documentation that the acuity adjustment mechanism has been developed in accordance with generally accepted actuarial principles and practices.

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 LTSS as defined at 42 CFR § 438.2(a). All general rate development standards outlined in Section I of this guide apply to rate development for all covered populations and services, but this section provides additional guidance that is specific to rate development guidance for LTSS. In determining whether or not 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 of the guide regarding the required standards for rate development and CMS's expectations for

appropriate documentation required in the rate certification is also applicable for rates for provision of MLTSS.

B. Rate Development Standards

i. States may take different approaches for rate setting for MLTSS. The two most common approaches are to structure the rate cells:

(a) by health care status and the level of need of the beneficiaries ("blended"); or

(b) by the long-term care setting that the beneficiary uses ("non-blended").

C. Appropriate Documentation

i. 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 (e.g., blended, non-blended, etc.).

(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.

(c) Any other payment structures, incentives, or disincentives used to pay the MCOs, PIHPs or PAHPs (for example, states may provide additional payments to managed care plan(s) that transition beneficiaries from institutional long-term care settings into other settings, or may pay adjusted rates during time periods of setting transitions).

(d) The expected effect that managing LTSS has on the utilization and unit costs of services.

(e) 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).

ii. 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.

iii. 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 section 1902(a)(10)(A)(i)(VIII) ("new adult group") of the Act. For states that have previously covered the new adult group, this guide describes the additional information expected from states related to how the capitation rates or the rate development process has changed since the most recent rate certification. All general rate development standards outlined in Section I of this guide apply to rate development for all covered population and services, but this section provides additional guidance that is specific to rate development for the new adult group. 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 documentation 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 of the guide, the rate certification must describe the data used to develop new adult group rates, particularly where different or additional data was used.

B. For states that have covered the new adult group in Medicaid managed care plan(s) in previous rating periods (i.e., starting in 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021 and/or January through June 2022), CMS expects the rate certification, as supported by assurances from the state, to describe:

i. Any new data that is available for use in this 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 previous rating periods have differed from assumptions and expectations in previous rate certifications.

iv. How differences between projected and actual experience in previous rating periods have been used to adjust these rates.

2. Projected Benefit Costs

A. In addition to the guidance for all Medicaid managed care rate certifications described in Section I of the guide, 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 previous rating periods:

(a) Any data and experience specific to the new adult group covered in previous rating periods 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 rate certification.

(c) How assumptions changed from rate certification(s) for previous rating periods 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 the new adult group;

(v) differences in provider reimbursement rates or provider networks, including any differences between provider reimbursement rates or provider networks for new adult group rates and other Medicaid population rates;

(vi) other material changes or adjustments to the new adult group projected benefit costs; and

(vii) any changes to the benefit plan offered to the new adult group.

ii. For states that did not cover the new adult group in previous rating periods:

(a) Descriptions of any differences of the benefit plan offered to the new adult group population and other covered populations (i.e., the non-new adult group populations).

iii. For any state that is covering the new adult group, regardless if they have been covered in previous rating periods, the following key assumptions related to the new adult group must be identified and described in the rate certification and supporting documentation:

(a) acuity or health status adjustments (in most cases comparing new adult group enrollees to other Medicaid adult enrollees);

(b) adjustments for pent-up demand;

(c) adjustments for adverse selection;

(d) adjustments for the demographics of the new adult group;

(e) 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

(f) other material adjustments to the new adult group projected benefit costs.

B. 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 for all Medicaid managed care rate certifications described in Section I of the guide, 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 plan(s) in previous rating periods, 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 rate certification(s) for previous rating periods 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:

i. administrative costs;
ii. care coordination and care management;
iii. provision for operating or profit margin;
iv. taxes, fees, and assessments; and
v. other material non-benefit costs.

4. Final Certified Rates

A. In addition to the expectations for all Medicaid managed care rate certifications described in Section I of the guide, CMS requests under 42 CFR § 438.7(d)[44] that states that covered the new adult group in Medicaid managed care plan(s) in previous rating periods provide:

   i. A comparison to the final certified rates in the previous rate certification.

   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 42 CFR § 438.7(d) that states describe any risk mitigation strategy that is specific to the new adult group. In accordance with 42 CFR § 438.6(b), if the state utilizes risk-sharing mechanisms with its managed care plan(s)[45] these arrangements must be documented in the contract(s) and rate certification documents for the rating period prior to the start of the rating period,[46] and must be developed in accordance with § 438.4, the rate development standards in § 438.5, and generally accepted actuarial principles and practices. Risk-sharing mechanisms may not be added or modified after the start of the rating period.

B. For states that covered the new adult group in Medicaid managed care plan(s) in previous rating periods, CMS requests the following information:

   i. Any changes in the risk mitigation strategy from those used during previous rating periods.

   ii. The rationale for making the change in the risk mitigation strategy or removing the risk mitigation used during previous rating periods. For states that utilize a risk mitigation strategy specific to the new adult group for the initial rating period that included this population, CMS believes this risk mitigation strategy should continue to be utilized until the following three criteria are met:

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[44] 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 or not the information provided in addition to the rate certification is proffered by the State, the actuary, or another party.

[45] As used in section 438.6(b)(1), "risk sharing mechanisms" includes any and all mechanisms or arrangements that have the effect of sharing risk between the MCO, PIHP or PAHP and the state *on an aggregate level*; these include risk mitigation strategies and other arrangements that protect the state or the MCO, PIHP, or PAHP against the risk that the assumptions used in the initial development of capitation rates differ from actual experience. Common risk mitigation strategies include reinsurance, risk corridors, stop-loss limits, a medical loss ratio (MLR) with a remittance, or a risk-based reconciliation payment. 2020 Final Medicaid and Children's Health Insurance Program (CHIP) Managed Care Rule published in the Federal Register on November 13, 2020 (CMS-2408-F) (85 FR 72754, 72774)

[46] Please see footnote 7 for additional documentation requirements for risk-sharing strategies.

(a) The state uses data only from the new adult group's experience to develop capitation rates;

(b) The state has settled or reconciled previous risk mitigation terms in their contract (e.g., MLR, risk corridor) to assess the appropriateness of their previous rate development; and

(c) The state can demonstrate that capitation rates are stable, or that rates have been adjusted consistent with differences in early experience.

iii. Any relevant experience, results, or preliminary information available related to the risk mitigation strategy used during previous rating periods.

Appendix A: CMS MEDICAID MANAGED CARE RATE DEVELOPMENT SUMMARY FOR ACCELERATED RATE REVIEWS

Introduction

As part of the Centers for Medicare & Medicaid Services' (CMS) review of Medicaid managed care rates, CMS is implementing procedures for an accelerated rate review. This appendix summarizes the accelerated rate review process and procedures, criteria for a state to use the accelerated rate review process and procedures, and the documentation required from a state that participates in the accelerated rate review process and procedures. In particular, states that elect to use the accelerated rate review process must also submit a Rate Development Summary that identifies several key elements. The elements of the Rate Development Summary are described further below. The accelerated rate review process will focus on reviewing those key elements.

To qualify for review under the accelerated review process and procedures, a rate certification must meet the criteria outlined below. The accelerated review will be of all rates covered by a rate certification that qualifies for accelerated review. Each state ultimately elects whether to request to participate in the accelerated rate review process. A state may have one or more rate certifications for its Medicaid managed care program(s) reviewed through the accelerated process, depending on the state's election and whether the particular rate certification qualifies. Rate certifications and rate amendments to those certifications may qualify for the accelerated review process.

A full review of all rate certifications will be required every 3 years, or more frequently if CMS determines a full review must be performed. Amendments to initial rate certifications reviewed under the accelerated rate review process will also be reviewed under the accelerated rate review process, unless the rate amendment does not meet the criteria (below) or CMS has identified material issues in the initial rate certification for the rate amendment.

Under the accelerated rate review process, for certifications that meet qualifying criteria, states must submit the following:

(1) the Rate Development Summary,
(2) the full rate certification and related supporting documents, and
(3) the executed managed care plan contracts for the certified rates.

All materials described in this Rate Development Guide must be submitted plus the Rate Development Summary. The accelerated review will focus on the elements in the Rate Development Summary, and CMS's review will extend to the full rate certification when more support, detail, or clarification is needed for the review. In the event there are still questions after

that initial review, CMS will contact that state and the actuary with questions (which may be in writing and/or through a call).

Criteria for a Rate Certification to Qualify for Accelerated Rate Review

Several criteria must be met for a rate certification to qualify for accelerated rate review for the rating period beginning between July 1, 2023 – June 30, 2024. The criteria include:

1. The state submits a timely request for the accelerated review process and timely submits the rate certification and required materials for review. Further information is in the "Required Submission Process and Materials" section below.
2. The CMS review of the prior rating period's capitation rate certification must be completed.
3. At least one of the two prior rating periods had a full review of the capitation rate certification.
4. The managed care program covered by the rate certification has been in operation for at least 24 months.
5. The same actuary or actuarial firm has developed the rates for and since the previous full review, including the rates submitted to the accelerated rate review process and procedures.
6. No material issues have been identified (by any party) in rate setting for the prior rating period. Material issues are generally identified through extensive questioning or conference calls. CMS retains discretion to determine whether or not material issues were identified in rate setting for the prior rating period; therefore, states should give CMS prior notice if they intend to participate in the accelerated rate review.
7. There are no material policy, programmatic, or legal issues related to the state's managed care program, either in the prior rating period or for the rating period under review.
8. The actuary is certifying rates or rate ranges consistent with the certification covered by the previous full review. For example, if the actuary certified rates in calendar year 2023, which was the last full review, and the state would like to participate in the accelerated review for calendar year 2024, the actuary must certify rates and not rate ranges.

CMS retains the discretion to review the rates and rate certification for a particular managed care program using these accelerated rate review procedures or a full rate review. The following criteria are a non-exhaustive list of considerations CMS will use in determining whether to use the procedures for a full review or an accelerated rate review:

1. Identification of any material rate setting issues during the accelerated review.

2. Identification of significant discrepancies or errors in the Rate Development Summary or rate certification materials.
3. Identification of significant changes to the rate development methodologies and/or the program.

CMS may choose to request additional information or corrective action in lieu of a full review of a rate certification.

Required Submission Process and Materials

States must adhere to the following procedural requirements to participate in the accelerated rate review:

1. Request to participate in the accelerated review 120 days in advance of the start of the rating period by submitting the request to MMCratesetting@cms.hhs.gov *and* MCOGDMCOActions@cms.hhs.gov. One request per certification should be submitted.

   States may send questions regarding eligibility to participate in the accelerated rate review process to MMCratesetting@cms.hhs.gov.

   CMS will notify the state within 2 weeks after their request to participate in the accelerated rate review if the certification qualifies for the accelerated review.

2. Submit the following documents to MMCratesetting@cms.hhs.gov *and* MCOGDMCOActions@cms.hhs.gov at least 90 days in advance of the rating period:
   (1) The Rate Development Summary, including all of the elements outlined in the next section;
   (2) The full rate certification and all supporting documentation; and
   (3) Fully executed contract(s) with signature pages for every managed care plan operating in the Medicaid, combined Medicaid/CHIP or separate CHIP managed care program(s) associated with the rate certification subject to the accelerated rate review.
      i. Because many states face challenges in providing rate certifications and executed contracts at the same time, CMS will accept finalized rate certifications before the state submits all other finalized components of the standardized contract submission.
      ii. Note: Some contract submissions also require additional documentation, such as the annual summary of managed care plans' medical loss ratio reports, readiness review results and/or parity analysis. Please see the

Addendum included in CMCS Informational Bulletin, dated November 8, 2019, for additional guidance.

Required Elements for Rate Development Summary

1. **Rates**

   The Rate Development Summary must identify all certified rates for the rating period and must indicate whether (i) the certified rates have been risk adjusted or (ii) the actuary has certified the risk adjustment methodology and the certified rates will be risk adjusted in the future, or (iii) the certified rates are not and will not be risk adjusted.

   The rates can be provided in two ways. CMS prefers that a table is provided, such as the one below.

Rate Cell (Region, Managed Care Plan, etc.)	**Rate (PMPM)**
A	$X
B	$X
C	$X

   Alternatively, the Rate Development Summary can specify exactly where this level of detail is provided in the rate certification (and any additional materials).

2. **Changes in rates from last rating period or initial certification**

   The Rate Development Summary must compare the rates for this rating period to either (1) the rates from the previous rating period in the case of a new certification or (2) the rates from the initial certification or most recent rate amendment in the case of a rate amendment. This will be used to identify rate changes that are unusually large or that appear to be inconsistent with the changes described in the certification.

   The information about rate changes can be provided in two ways. CMS prefers that a table is provided such as below.

Rate Cell (Region, Managed Care Plan, etc.)	**Rate**	**Previous Rate**	**Change**
A	$X	$Y	Z%
B	$X	$Y	Z%
C	$X	$Y	Z%

Average	**$X**	**$Y**	**Z%**

Average rate changes would also be helpful, and could be provided overall for the rate certification or as appropriate subtotals (aggregating related rate cells together, aggregating all rate cells by managed care plan, etc.). The table can also split the rate change into components if available (for example: projected-to-historical cost differences, trend, programmatic changes, etc.).

Alternatively, the Rate Development Summary can specify exactly where in the rate certification (and any additional materials) that the rate changes are provided at this level of detail.

3. Base Data

The Rate Development Summary must include a description of the base data used, including:

(1) The sources of data used for the base data (encounter data, fee-for-service data, or other sources).
(2) An assurance that the base data is consistent with the requirements in 42 CFR § 438.5(c)(3), or an explanation of why the base data is inconsistent with the regulation including the state's rationale of why an exemption is necessary and a description of the corrective action plan to come into compliance with the base data standards no later than 2 years after the last day of the rating period for which the deficiency was identified in accordance with 42 CFR § 438.5(c)(3).
(3) A description of any data quality issues or concerns identified by the actuary.
(4) A description of any material adjustments made to the base data.
(5) References to where the data is described in more detail in the certification and any additional documents. In addition, the Rate Development Summary can include references to the summarized base data in the certification or additional documents.

This documentation will be used to verify that the data used is consistent with CMS regulation and actuarial standards as well as to assess any significant data issues or adjustments made to the data for developing rates.

4. Methodology

The Rate Development Summary must include a high-level description of the methodologies used to develop the rates. This section must include a description of any

material methodology changes since the last certification and references to descriptions of the methodologies in the rate certification.

5. Trend

The Rate Development Summary must include a summary of the projected benefit cost trends used to develop the rates, including:

(1) the total average projected benefit cost trend assumption;
(2) the projected benefit cost trends by category or type of service;
(3) the projected benefit cost trends by rate cell (or similar level of detail, such as eligibility category);
(4) the projected benefit cost trends separated into price or unit cost trends, and utilization trends;
(5) any adjustments applied to develop the projected benefit cost trends;
(6) comparisons to the previous year's trends; and
(7) references to where the trends and their development are described in more detail in the certification and any additional documents.

This information will be used to verify that the trends are reasonable and consistent with the changes being made to the rates (either in the initial certification or in the rate amendment) and to identify trends that are unusual (for example, larger than expected or negative), or that appear to be inconsistent with the changes described in the certification or rate amendment.

The trends can be provided in several ways. First, the trends can be provided in the tables in the template. CMS believes that tables showing the trends by service and the average trend by rate cell would be the most useful:

Category of Service	**Unit Cost Trend**	**Utilization Trend**	**Adjustments to Trend**	**Overall Trend**
A	X%	Y%	Z%	A%
B	X%	Y%	Z%	A%
C	X%	Y%	Z%	A%

Rate Cell (Region, Managed Care Plan, etc.)	**Trend**
A	A%
B	A%

C	A%
Total Average	**A%**

Alternatively, the Rate Development Summary can specify exactly where in the rate certification (and any additional materials) the trends are provided at this level of detail.

6. Non-benefit costs

The Rate Development Summary must summarize non-benefit costs by type or by category (for example, administrative costs, care management (non-benefit), taxes and fees, and profit margin). The Rate Development Summary should also identify where the non-benefit costs are described in the rate certification and any additional documents, as well as any comparisons to the previous year's non-benefit costs.

This information will be used to verify that the non-benefit costs are reasonable and consistent with the changes being made to the rates (either in the initial certification or in the rate amendment) and to identify costs that are unusual (for example, significant larger or smaller than typical), or that appear inconsistent with the changes described in the certification or rate amendment.

The non-benefit costs can be provided in several ways. First, non-benefit costs can be shown by rate cell (or similar level of detail) or an average across all rate cells if costs are similar:

Type of Non-Benefit Cost	**Amount**	**Amount in Previous Rating Period**	**Percentage Change between Rating Periods**
A	X% or $Y PMPM	X% or $Y PMPM	%
B	X% or $Y PMPM	X% or $Y P MPM	%
C	X% or $Y PMPM	X% or $Y PMPM	%
Total	**Z% or $A PMPM**	**Z% or $A PMPM**	**%**

Alternatively, the Rate Development Summary can specify exactly where in the rate certification (and any additional materials) that the non-benefit costs are provided at this level of detail.

7. Program changes

The Rate Development Summary must describe any programmatic changes and the impacts that they have on the certified capitation rates. Programmatic changes must be documented in this Rate Development Summary including new or changing benefits; changes to provider reimbursement; new or changing populations covered by managed care; new programs or initiatives that affect managed care; new managed care plan(s) or changes in participating managed care plan(s); and any other changes to the managed care program that have a material impact on the rates.

This section must include a description of those changes and the impacts on the rates, and must have references to where these are described in more detail in the certification. This information will be used to verify that the program changes are consistent with the changes being made to the rates and to identify large or unusual impacts to the rates.

8. Financial performance

The Rate Development Summary must include recent financial performance of the managed care program as a whole and by individual managed care plan in the program, which could include medical loss ratio (MLR) and/or profit margin by managed care plan. The state must provide some measure of financial performance (MLR or profit margin, preferably by managed care plan, by program, by year) and a comparison to the estimated or assumed measure when developing the rates. The Rate Development Summary must include up to 3 years of experience (or, if the rate certification is for a program with less than 3 years experience, all available years) and a brief definition of the financial performance measure chosen.

This information will be used as a basis for reviewing past results, including the accuracy of previous rate setting and the stability of program costs and rates. CMS will review any unexpected results or changes to assess if the proposed rates are consistent with expectations given recent financial performance (for example, if costs have generally been higher than expected, CMS would expect larger rate increases holding all other factors constant).

This information could be provided in one of two ways. CMS prefers the information in a table such as the one below for each year.

Managed Care Plan	**Estimated MLR/Profit Margin**	**Actual MLR/Profit Margin**
A	X%	Y%
B	X%	Y%

C	X%	Y%
Average	**X%**	**Y%**

Alternatively, the Rate Development Summary can specify exactly where in the rate certification (and any additional materials) that the financial performance results and comparisons are provided.

9. Addressing previous issues

The Rate Development Summary must include a section for the state and its actuary to address any significant issues identified in previous years (if applicable). CMS previously communicated issues to states through approval letters (prior to October 2017), and has also communicated significant issues through calls, emails, or inquired about significant issues during rate certification reviews. This section must include a description of how any issues were considered in setting the rates in the certification or rate amendment, as well as references to where this is described in more detail in the certification.

10. Other rate and policy items

The Rate Development Summary must identify any of the following items that are applicable to the capitation rates and/or the managed care program for the rating period. For each item, this section must include a description of how the item was considered in setting the rates in the certification or rate amendment, as well as references to where each item is described in more detail in the certification.

- Institution of mental disease (IMD) services;
- State directed payments (42 CFR § 438.6(c));
- Pass-through payments (42 CFR § 438.6(d));
- Additional payments added to the rates that currently do not qualify as state directed payments or pass-through payments;
- Confirmation that any proposed differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations comply with 42 CFR § 438.4(b)(1);
- Withhold arrangements;
- Incentive arrangements;
- Risk adjustment;
- Acuity adjustment;
- Reinsurance;
- Minimum medical loss ratio (MLR) requirements;
- Risk corridors;
- Other risk-sharing strategies; and

- Other notable policy, Medicaid authority, or programmatic changes.

Appendix B: DOCUMENTATION EXPECTATIONS FOR THE ACTUARIAL REPORT CONTAINING THE FINAL ILOS COST PERCENTAGE AND SUMMARY OF MANAGED CARE PLAN ILOS COSTS

CMS expects the following documentation will be provided to CMS, in an actuarial report separate from the rate certification(s), for the documentation requirements for the final ILOS Cost Percentage outlined in Section I, Item 3.A.iv of the rate guide. For each Medicaid managed care program that includes an ILOS, excluding short term stays in an IMD, provide:

1. The portion of the total capitation payments paid to managed care plans that are attributable to ILOSs, excluding short term stays in an IMD, for the specific managed care program that includes the ILOS, and a description of how this amount was calculated.

2. The total actual dollar amount of capitation payments paid to managed care plans specific to the Medicaid managed care program that includes the ILOSs. This total capitation payment amount must include all state directed payments in accordance with 42 CFR § 438.6(c) and pass-through payments in accordance with 42 CFR § 438.6(d).

3. The final ILOS Cost Percentage specific to the Medicaid managed care program. This percentage is calculated by dividing the amount from Step 1 by the amount from Step 2.

4. A summary of the actual managed care plan costs for delivering ILOSs based on claims and encounter data provided by the managed care plans to States. This summary should include reported enrollment by rate cell, and total utilization and managed care plan spending on each ILOS separately by rate cell.

5. A certification from the State’s actuary that the information provided in the actuarial report is accurate to the best of their knowledge and consistent with any applicable guidance or regulations.