Analysis of 2021-2022 Medicaid Managed Care Rate Development Guide

For rating periods starting between July 1, 2021 and June 30, 2022

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Executive summary

On June 25, 2021, the Centers for Medicare & Medicaid Services (CMS) released the 2021-2022 Medicaid Managed Care Rate Development Guide (Guide) for rating periods starting between July 1, 2021 through June 30, 2022. In this paper, we provide a summary of the changes from the previous guide (2020-2021) to aid states' actuaries in understanding and complying with federal regulations. It is important to recognize and implement these changes in capitation rate certification materials as many of them aim to ease the CMS review process for states' capitation rates.

Several of the updates to the Guide reflect the Medicaid Managed Care Final Rule (Final Rule) published November 13, 2020.[i] Throughout the document, CMS has changed the language referring to Sections within the Guide, to more explicitly refer to the federal rate development standards in 42 CFR § 438.4 through 438.7. The Guide was also updated to reflect State Directed Payments clarifications and preprint template changes, published January 8, 2021, in a letter to State Medicaid Directors.[ii]

Complete copies of both the updated and previous version of the Guide are included as appendices, with the differences between the two highlighted. Descriptions of the changes are included below in two main sections: Key Changes and Other Notable Items. Guide section references are provided following the description of the changes where applicable.

Key changes in this update are:

1. Rate ranges permissible
2. Documentation of COVID-19 impacts
3. Expanded language on federal financial participation (FFP)
4. State directed payments – documentation aligned with updated preprint template requirements[iii]
5. Pass-through payments – documentation of non-federal share financing and new flexibility for states transitioning services and populations from fee-for-service (FFS) to managed care delivery systems
6. Risk-sharing mechanisms must be documented prior to the start of the rating period

Other notable items:

1. Rating periods other than 12 months
2. Retroactive adjustments to capitation rates
3. When a rate amendment and contract amendment are required
4. Health Insurance Providers Fee repeal
5. Rate development standards for Section II (Long-Term Services and Supports) and Section III (New Adult Group)
6. Minor changes to Appendix A (Accelerated Rate Reviews)

Description of appendices

APPENDIX 1

Appendix 1 is a copy of the 2020-2021 Medicaid Managed Care Rate Development Guide, with red highlighting that indicates language that has been altered or removed.

APPENDIX 2

Appendix 2 is a copy of the 2021-2022 Medicaid Managed Care Rate Development Guide, with green highlighting that indicates language that has been altered or added.

Key changes

1. RATE RANGES PERMISSIBLE [SECTION I.A.VIII]

In accordance with the Final Rule, actuaries now have the option to certify either a capitation rate range or a specific rate for each rate cell. The certification must clearly indicate whether the actuary is certifying a rate range or discrete capitation rates. The certification must document a number of items for actuarially sound rate ranges; including [Section I.B.iv]:

- Data, assumptions and/or methods used to develop the upper and lower bounds;
- That the upper bound does not exceed the lower bound by more than 5%;
- Criteria for paying at different points within the range among contracted MCOs[iv]; and,
- Clear indication that the actuary is certifying both the upper and lower bound of the rate range as actuarially sound.

CMS indicates that this information can be contained in the relevant sections of the certification, or in a special section dedicated to the development of the rate range.

The Guide also specifies procedures for rate and contract amendments for actuaries certifying rate ranges. Capitation rates within a certified actuarially sound rate range cannot be modified without a revised rate certification unless the changes to the paid capitation rates are less than 1.0% within the certified rate range [Section I.A.ix.(c)]. For these limited payment changes, new or revised rate certifications are not required [Section I.A.xiii.(d)]. For changes greater than 1.0%, additional documentation is required, including a revised rate certification. It should be noted that the 1% flexibility permitted within a rate range is more limited than the *de minimis* rate adjustment permissible when rate ranges are not in use, which is specified as less than 1.5% of the capitation rate per rate cell, consistent with 42 CFR § 438.7(c)(3).

In addition, Accelerated Rate Reviews require that the choice to certify a rate or rate range must be consistent with the previous full review. As stated by CMS in the Final Rule, this change provides state programs that develop rate ranges with greater flexibility in the rate certification process.

2. DOCUMENTATION OF COVID-19 IMPACT

CMS expects that states and their actuaries will evaluate how the capitation rates account for the direct and indirect impacts of the COVID-19 public health emergency (PHE). States and their actuaries should evaluate data that is available and applicable for determining how to address the COVID-19 PHE in the rate development process. States and their actuaries must also document the approach to address the impact of the COVID-19 PHE in the rate certification to ensure the rates are actuarially sound in accordance with 42 C.F.R. § 438.4. [Section I.1.A.xii] & [Section I.1.B.x]. CMS recommends all states implement a 2-sided risk mitigation strategy for rating periods impacted by the PHE.[v] In compliance with the requirements in 42 C.F.R. § 438.6(b)(1), states must document the risk mitigation strategy in the contract and rate certification documents for the rating period prior to the start of the rating period.

The documentation requirements for the accounting of the COVID-19 PHE in rate development must include the following:

- Description of data for determining how to address the COVID-19 PHE in rate setting;
- Description of COVID-19 PHE impacts, such as enrollment changes, treatments and vaccines, deferred care, expanded coverage of telehealth, etc.; and,
- Description of risk mitigation strategies and how the it compares to the prior rating period (if any).

3. EXPANDED LANGUAGE ON FEDERAL FINANCIAL PARTICIPATION (FFP)

Consistent with requirements from the Final Rule, CMS included additional language to state that the development of capitation rates must not vary with the rate of FFP in a manner that increases federal costs. 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. For example, without providing a valid explanation, an actuary cannot include a higher risk margin for a population with an enhanced FFP than for a population with standard FFP. In addition, CMS now requires the rate certification to include an assurance to this effect. [Section I.1.A.iv] & [Section I.1.B.vi]

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 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:

- Description of each assumption, methodology, or factor that varies by the rate of FFP;
- Justification of how each difference in the assumptions, methodologies, or factors used represents actual cost differences; and,
- Financial impact on federal costs of the difference in assumptions, methodologies, or factors used that varies by the rate of FFP.

4. STATE DIRECTED PAYMENTS

In accordance with the updated Final Rule, 42 C.F.R. § 438.6(c)(2) requires all state directed payments to receive CMS approval before implementation. The state directed payments included in the rate certification must be consistent with the information in the applicable Section 438.6(c) preprints. The method by which a state incorporates a state directed payment (as an adjustment or through a separate payment term) will be identified and documented as part of the preprint review process[6]. [Section I.4.D.i] & [Section I.4.D.ii]

In addition to the documentation of state directed payments in the body of the certification, the state must provide information for each state directed payment in the table formats specified in the Guide. Depending on whether the payment is applied as a rate adjustment or separate payment term, CMS specifies different table formats to capture the information requested. Note that while the information requested is broadly similar to the prior rate guide, each state directed payment (whether rate adjustment or separate payment term) must be identified separately and the impacts of different payments cannot be combined.

5. PASS-THROUGH PAYMENTS [SECTION I.4.E]

(a) CMS made updates to pass-through payment guidance and documentation for states transitioning services and populations from FFS to managed care delivery systems:

- As permitted by the Final Rule, a footnote was added to clarify that temporary pass-through payments are allowable for states transitioning services and populations from a FFS delivery system to a managed care delivery system [Footnote 29 - Section I.4.E.i.(b)], with no requirement to demonstrate that managed care contracts were in existence for the rating period that includes July 5, 2016 or periods prior (as defined in 42 C.F.R. § 438.6(d)(1)(i)).
- The aggregate amount of the pass-through payment must be “less than or equal to the amounts calculated in 42 C.F.R. § 438.6(d)(iii)(A), (B), or (C)”. [Section I.4.E.i.(c).(iii)]
    - The amount of each component 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”. [Section I.4.E.i.(c).(iii).(A)]
- Additionally, the documentation must include:
    - “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” [Section I.4.E.ii.(b).(iv).(A)]
    - “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” [Section I.4.E.ii.(b).(iv).(B)]
    - Description of the data, methodologies, and assumptions used to develop the required calculations [Section I.4.E.ii.(d)]

(b) CMS also made updates to pass-through payment documentation:

- The description of each pass-through payment must include "a description of how the pass-through payment will be paid (e.g. aggregate or PMPM amount where the final aggregate payment varies based on actual enrollment)" [Section I.4.E.ii.(a).(ii)]
- For each pass-through payment, the financing mechanism of the pass-through payment must also be documented. Additional detail can be found in [Section I.4.E.ii.(a).(vi).(A)], but it appears that CMS is aiming to align rate setting requirements with the revised preprint template to be used for all contract rating periods that begin on or after July 1, 2021[vi], as well as the letter to State Medicaid Directors regarding additional guidance on state directed payments[vii]. Additional documentation requirements include the source of the non-federal share of the payment arrangement as well as a table of information to be populated for intergovernmental transfer (IGT) entities. For any payment funded by IGTs, required documentation includes: [Section I.4.E.ii.(a).(vi).(B)]
  - Complete list of entities transferring funds
  - Operational nature of each entity transferring funds (state, county, city, other)
  - Total amounts transferred by each entity
  - General taxing authority of the transferring entity
  - Amount of appropriations (if any) received by the transferring entity
  - Identification of 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
- For the base amount for hospital pass-through payments, there must be an explanation of any changes to the methodology utilized to for the base amount calculation relative to the previous years', including fiscal impact [Section I.4.E.ii.(c).(i).(B)]

6. RISK-SHARING MECHANISMS MUST BE DOCUMENTED PRIOR TO THE START OF THE RATING PERIOD

In accordance with the updated Final Rule, 42 C.F.R. § 438.6(b) requires risk-sharing mechanisms to be documented in the contract and rate certification prior to the start of the rating period. Effective December 14, 2020, risk-sharing mechanisms may no longer be added or modified after the start of the rating period. These arrangements must be developed in accordance with § 438.4, the rate development standards in § 438.5, and generally accepted actuarial principles and practices [Section I.4.C.i.a]. This same requirement was also specifically noted again for the New Adult Group [Section III.5.A].

Other Notable Items

1. RATING PERIODS OTHER THAN 12 MONTHS

Rate certifications must be done for a 12-month rating period. CMS removed language in the prior rate development guide that it would consider a time period other than 12 months to address unusual circumstances, such as when the state is trying to align program rating periods, or when the state needs to make a rate adjustment due to a contract amendment. [Section I.1.A.ii]

2. RETROACTIVE ADJUSTMENTS TO CAPITATION RATES

CMS clarified that if a retroactive adjustment to the capitation rates is necessary, it is acceptable to provide either a new rate certification or a rate amendment. The new certification or amendment must additionally include a description of whether the state adjusted rates by a *de minimis* amount prior to submission of the rate amendment, as well as address and account for all differences from the most recently certified rates. The *de minimis* rate adjustment is specified as less than 1.5% of the capitation rate per rate cell, consistent with 42 CFR § 438.7(c)(3). As noted previously, this amount is 1.0% for capitation rate ranges [Section I.A.ix.(c)]

3. WHEN A RATE AMENDMENT AND CONTRACT AMENDMENT IS REQUIRED

If the actuary is certifying rates (not rate ranges), the state must submit a revised rate certification when rates change, except for changes permitted as specified in 42 C.F.R § 438.4(c) or 42 C.F.R § 438.7(c)(3). For adjustments that result in an increase or decrease of more than 1.5% from the most recently certified capitation rates for any rate cell, states will need to submit a rate amendment and contract amendment. [Section I.1.A.xiii]

If the state increases or decreases the capitation rates per rate cell within the certified rate range (up to 1%), the state 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. [Footnote 14 - Section I.1.A.xiii.(d).(ii)]

Additionally, 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. [Section I.1.A.xiii.(f)]

4. HEALTH INSURANCE PROVIDERS FEE REPEAL

The fee is repealed by the Further Consolidated Appropriations Act, 2020, Division N, Subtitle E § 502 for calendar years beginning after December 31, 2020. Therefore, CMS has removed the language regarding the fee in [Section I.5.A.iv].

5. RATE DEVELOPMENT STANDARDS FOR SECTION II AND SECTION III

All general rate development standards outlined in Section I of the rate development guide apply to Section II and Section III. CMS acknowledges that the Section II and Section III are for additional guidance that is specific to rate development for long-term services and supports (LTSS) and new adult group, respectively. [Section II Introduction] & [Section III Introduction]

6. MINOR CHANGES IN APPENDIX A (ACCELERATED RATE REVIEWS)

CMS added Appendix A, guidance for an accelerated rate review process, for the first time in the 2020-2021 Guide. There are a few minor changes to that guidance for the 2021-2022 Guide, including:

- An additional criteria for qualifying for accelerated review includes that the actuary is certifying rates or rate ranges consistent with the certification covered by the previous full review. This means that if the actuary is certifying rate ranges in 2022, but certified rates in 2021, the rate range would not qualify for accelerated review.
- Additional guidance for submission process.
- Implementation of two-year time limit on base data compliance.
- Additional columns added to suggested table for non-benefit costs for amounts in previous rating period and percentage change between rating periods.

[i] https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care
[ii] https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21001.pdf
[iii] See https://www.medicaid.gov/medicaid/managed-care/downloads/sdp-4386c-preprint-template.pdf for a copy of the Section 438.6(c) preprint submission template.
[iv] For example, if the criteria is related to state negotiation or a competitive bidding process, the rate certification must identify which components of the capitation rates varied due to the negotiation or bidding, and document how those variation produced different points within the rate range.
[v] For additional information, please see: https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib051420.pdf
[vi] See https://www.medicaid.gov/medicaid/managed-care/downloads/sdp-4386c-preprint-template.pdf for a copy of the Section 438.6(c) preprint submission template.
[vii] https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21001.pdf

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