MILLIMAN MEDICAID ISSUE BRIEF

Analysis of 2020-2021 Medicaid Managed Care Rate Development Guide

For rating periods starting between July 1, 2020 and June 30, 2021

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Executive summary

On July 2, 2020, CMS released the 2020-2021 Medicaid Managed Care Rate Development Guide (Guide). To facilitate understanding and compliance, this paper provides a comparison of the year-over-year changes between the two most recent versions of the Guide. Gaining an effective understanding of the Guide and the latest changes will allow states to develop capitation rates and obtain CMS approval in a more efficient manner. Complete copies of the Guides are provided as appendices, with differences between the two versions highlighted. Descriptions of the changes are outlined below, grouped into two categories of significance: key changes and clarifying items. Section references are provided following the description of changes where applicable.

Key changes in this update are:

1. Emphasis on timely filing for claiming federal financial participation
2. Known future amendments must be listed
3. Directed payments – significant additional documentation
4. Pass-through payments – additional guidance and documentation, especially regarding hospital pass-through payments
5. Disclosure of plan-reported non-benefit costs
6. Accelerated rate review guidance

Clarifying items include:

1. More prescriptive language throughout the Guide to eliminate ambiguity
2. Explicit reference to MLR requirements related to third-party vendors
3. Rate amendments must be submitted to remove costs no longer permissible by law
4. Rate ranges not allowed and assumptions that vary by plan must be explained
5. Services, populations, or programs with different FMAP – costs must be separately shown as part of the certification
6. Minor additional documentation for projected benefit costs and trends
7. Incentive and withhold arrangement documentation
8. Health Insurance Providers Fee repeal
9. New adult group – benefit plan changes or differences

Description of appendices

APPENDIX 1

Appendix 1 is a copy of the 2019-2020 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 2020-2021 Medicaid Managed Care Rate Development Guide, with green highlighting that indicates language that has been altered or added.

Key changes

1. TIMELY FILING

CMS added an element specifically stressing that in order to receive federal financial participation (FFP), states must comply with timely filing requirements, citing section 1132 of the Social Security Act[1] and 45 CFR part 95[2]. There is a two-year period for claiming FFP. [Section I.1.A.ix.a]

There is a two-year period for claiming FFP. As an example, if a state wanted to amend capitation rates for the first quarter of 2019, the adjusted amount must be paid no later than the first quarter of 2021, with FFP claimed on the CMS-64 form at that time. In our experience with CMS, the exception for "adjustments to prior year costs" no longer applies to capitation rate amendments.

2. FUTURE AMENDMENTS

Anticipated future amendments must now be listed in the rate certification, along with the expected timeframe for submission, and an explanation why these known changes may not be incorporated in the current rates. [Section I.1.B.vi]

This request may reflect a desire by CMS for fewer rate amendments to lessen the administrative burden on behalf of both the state and federal governments.

3. DIRECTED PAYMENTS

CMS made updates to the required documentation for directed payments:

- The impact the directed payment has on the rates must be provided for each rate cell. [Section I.4.D.ii.a.ii.B]
- Any adjustments applied to account for changes to the payment arrangement from the base data period must be described. [Section I.4.D.ii.a.ii.C]
- Consistency with the §438.6(c) pre-print extends to include any relevant correspondence between the state and CMS. Also, the certification must indicate when the pre-print will be submitted, if this has not already occurred. [Section I.4.D.ii.a.ii.D, Section I.4.D.ii.a.iii.F]
- In the case of a maximum fee schedule, instances where this threshold was surpassed in the base data must be identified, and an explanation for why the plans will be able to lower reimbursement accordingly must be included. If there are any exemptions to the maximum fee schedule, these must be identified and explained how they were considered in rate development. [Section I.4.D.ii.a.ii.E]
- In the case of a separate payment term, the certification requires a statement from the actuary certifying the amount of the separate payment term. [Section I.4.D.ii.a.iii.B]
- For separate payment terms, PMPM estimates for each rate cell for all payments must now be included. Previously, only "substantial" payments needed to be estimated. [Section I.4.D.ii.a.iii.E]
- It must be confirmed that there are no additional directed payments not addressed in the certification. [Section I.4.D.ii.b]
- The certification must also confirm that there are no requirements regarding plan reimbursement to providers aside from those identified in the certification as directed payments, or authorized under applicable law, regulation, or waiver. [Section I.4.D.ii.c]

4. PASS-THROUGH PAYMENTS

CMS made updates to the pass-through payment guidance and documentation:

- The calculated base amounts for pass-through payments must include the impact of §438.6(c) directed payments made to hospitals during the 12-month period immediately 2 years prior to the rating period [Section I.4.E.i.f]
- If the state applies a trend adjustment when calculating reasonable estimates of aggregate differences for the base amounts, it must include a justification, and the data source for trend should be consistent with other pass-through payment calculations. [Section I.4.E.i.g.i]
- If pass-through payments are implemented as PMPMs so that total payments vary with enrollment, actual payments must be monitored to ensure compliance with the total amount permitted under 42 CFR 438.6(d). If this amount is exceeded, a rate

amendment will be necessary. The maximum allowable amount for pass-through payments must also be included in the state contracts with the managed care plans. [Section I.4.E.i.i]

- The description of the pass-through payment must continue to include the amount of the payment (aggregate and PMPM), the providers receiving the payment, and the financing mechanism. CMS has added a request for the provider type, the program(s) that include the payment, and identification of any directed payments that target the same providers. It is no longer required to quantify pass-through payments included in the rates for the previous rating period. [Section I.4.E.ii.a]
- A description of pass-through payments by provider type must be provided, including the amount of pass-through payments in total and on a PMPM basis. [Section I.4.E.ii.b]
- Significant additional documentation specific to hospital pass-through payments is now required, regarding reasonable estimates, base data adjustments for calculations, trend adjustments, and the amount of §438.6(c) directed payments paid to hospitals. [Section I.4.E.ii.c]

5. DISCLOSURE OF PLAN-REPORTED NON-BENEFIT COSTS

The rate certification must now disclose historical non-benefit cost data provided by the health plans, along with an explanation of how this information was considered in rate development. [Section I.5.B.iii]

This is an additional documentation request, which indicates CMS may place more scrutiny on the development of administrative cost loads going forward.

6. ACCELERATED RATE REVIEW GUIDANCE

A significant new portion of the Guide relates to the novel accelerated rate review process. In the appendix, CMS details the qualification criteria, the necessary procedures, and the Rate Development Summary submission. [Appendix A]

The qualification criteria for accelerated rate review are outlined below:

- Timeliness of request and submission (described in greater detail in following paragraphs)
- Prior rating period's review must be complete
- There was a full rate certification review within the past two rating periods (a full review is required every three years)
- The program has been in operation for at least 24 months
- The state's actuary (or actuarial firm) remains the same as the previous full review
- No material issues found in the prior rate setting
- No material policy, programmatic, or legal issues related to the state's managed care program

Determination of material issues and whether a full rate certification review is necessary is based on CMS discretion. They may also request additional information or corrective action instead of performing the full review.

In order to participate in the accelerated rate review process, the state must submit a request 120 days in advance of the rating period. CMS notes that due to the release date of this version of the Guide, this may not be feasible and encourage states to submit requests as soon as possible. Within two weeks, CMS will notify the state with their decision.

If the request is accepted, then the state must submit the appropriate materials at least 90 days before the rating period. The materials include the Rate Development Summary (described in greater detail below), the full rate certification and supporting documents, and executed contracts with all health plans. CMS acknowledges that they will accept the final rate certification in advance of the required contract materials.

The Rate Development Summary is additional documentation that highlights certain information included in the rate certification. This document will be the primary focus of CMS during the accelerated rate review. Note that this is not a replacement of the rate certification, as the review may extend to the certification when further detail is necessary. The components of the Rate Development Summary are outlined below:

- **Rates** – Provide the certified rates, along with an indication if they have been risk adjusted already or will be in the future. CMS prefers a rate table display, but alternatively the location of the rates in the certification may be specified.

- **Rate changes** – Provide a comparison of the rates to the previous rating period, or to the previous certification in the case of a rate amendment. CMS prefers a comparison table display, along with appropriate composites, but will also accept the alternative specification of where in the certification this information is shown.
- **Base data** – Describe the base data (data sources, compliance with regulatory requirements, data quality issues/concerns, and material adjustments). Include references to where the data is discussed in the certification and other supporting documentation.
- **Methodology** – Describe the rate development methodology at a high-level, including any material methodology changes. Include references to where the methodology is discussed in the certification and other supporting documentation.
- **Trend** – Trend information must be included, with the following stratifications: overall benefit cost trend, by category of service, by rate cell or population, and unit cost/utilization/adjustment breakouts. These must also be compared to the previous year's trend, and references to trend information in the certification must be provided. CMS prefers this information is illustrated in trend tables.
- **Non-benefit costs** – Summarize non-benefit costs by type and include references to where these costs are described in the rate certification. CMS prefers a tabular display of the non-benefit costs.
- **Program changes** – Describe any program changes as well as their impacts on the rates. Examples include benefit changes, provider reimbursement changes, population changes, new programs or initiatives, health plan changes, etc. Include references to where these are discussed in the certification.
- **Financial performance** – Provide recent financial performance metrics (e.g., MLR, profit margin) by plan. Include at least three years of experience, and compare to the estimated values from rate setting. The chosen metric must also be briefly defined. CMS prefers a table, but will also accept references to where this information is provided in the rate certification package.
- **Previous issues (if applicable)** – Describe how any potential issues identified in previous years were addressed. Include references to where these are discussed in the certification.
- **Other rate and policy items** – Identify and describe any of the following that apply. Include references where the corresponding information is located in the certification.
  - IMD services
  - Directed payments, pass-through payments, and/or other additional payments included in the rates
  - Confirmation that rate differences are not based on varying rates of FFP between populations
  - Withhold and incentive arrangements
  - Risk sharing strategies such as risk adjustment, acuity adjustment, reinsurance, minimum MLR requirements, and/or risk corridors
  - Other notable changes

Clarifying items

1. MORE PRESCRIPTIVE LANGUAGE

Throughout the document, CMS has used more prescriptive and specific language to remove any potential ambiguity regarding requirements. Examples include replacing "should" or "it is expected" with "must", or requests that certifications directly "provide" information rather than "describe". For brevity, a comprehensive list of all changes is not included in this report, but we encourage the reader to use the included appendices that highlight year-over-year changes.

To be clear, thorough rate documentation should already include all items indicated in the Guide, but continual attention to the precise language must be paid to ensure all CMS requirements continue to be addressed.

2. MLR REQUIREMENTS RELATED TO THIRD-PARTY VENDORS

Within the section outlining MLR guidance, there is a new footnote directly referencing the informational bulletin regarding MLR requirements pertaining to third-party vendors[3, 4]. [Footnote 7 – Section I.1.A.vi]

3. COSTS NO LONGER PERMISSIBLE BY LAW

In instances where Medicaid program features are no longer allowable under law (e.g., due to a court case, or a change in federal regulations), a rate amendment must be submitted to remove the impermissible costs from the capitation rates. [Section I.1.A.ix.f]

4. RATE RANGES NOT PERMISSIBLE

CMS notes that while ranges for assumptions and adjustments may be useful for developing rates, the final certified rates must reflect specific point estimates and it is reiterated that rate ranges may not be certified. If underlying assumptions vary between managed care plans, the certification must include an explanation for these differences. This increased documentation may most impact programs in which rates vary by health plan due to a competitive bidding process. [Section I.1.B.ii]

5. SERVICES, POPULATIONS, OR PROGRAMS WITH DIFFERENT FMAP

In earlier guidance, CMS requested that costs subject to a different FMAP than the standard state level *should* be shown in the rate certification. In this year's Guide, it is now a requirement that costs for services, populations, or programs with a different FMAP *must* be separately shown in the rate certification. [Section I.1.B.iv]

This is a noteworthy example of the more prescriptive language employed by CMS as described above.

6. ADDITIONAL DOCUMENTATION FOR PROJECTED BENEFIT COSTS AND TRENDS

The trend documentation should include citations for data sources, with an emphasis on external sources aside from actual experience. [Section I.3.B.iii.a.i.A]

If additional services for compliance with mental health parity standards are necessary, an assurance of payment adequacy must be included in the rate certification. [Section I.3.B.iv.d]

There is an additional reminder that costs of an IMD as an in-lieu-of-service may not be reflected in the rates. [Section I.3.B.v.d]

7. INCENTIVE AND WITHHOLD ARRANGEMENT DOCUMENTATION

The Guide clarifies that the rate certification must include confirmation that the *total payments* under the incentive arrangement (capitation and incentive payments combined) will not exceed 105% of the capitation payments. [Section I.4.A.i.a.i, Section I.4.A.ii.a.iv]

Within the documentation regarding the time periods of incentive and withhold arrangements, CMS indicates these time periods must not be longer than the rating period. [Section I.4.A.ii.a.i, Section I.4.B.ii.a.i]

The description of withhold arrangements must include the enrollees, services, and providers covered. [Section I.4.B.ii.a.ii]

8. HEALTH INSURANCE PROVIDERS FEE REPEAL

CMS indicates the fee is in effect for calendar year 2020, but thereafter is repealed by the Further Consolidated Appropriations Act, 2020, Division N, Subtitle E §502. [Section I.5.A.iv.a]

9. NEW ADULT GROUP

Throughout the entire section, this population is specifically referred to as the "new adult group" rather than "newly eligible adults". [Section III]

The standard data descriptions must be included as referenced in Section I, but CMS emphasizes additional documentation if different or additional data was used for this population. [Section III.1.A]

The dates of previous rating periods have been extended to include 2017, 2018, 2019, and January through June 2020. [Section III.1.B]

If a state covered the new adult group in previous rating periods, benefit plan changes since the previous rate certification must be described. [Section III.2.A.i.c.vii]

If a state did not cover the new adult group in previous rating periods, benefit plan differences compared to other covered populations must be described. [Section III.2.A.ii.a]

There appears to be a typographical error in which one bullet point was cut off and combined with the subsequent one. Until this issue is resolved, we note that the previous Guide included the following language (apparent omission emphasized):

> *C. The rate certification and supporting documentation must describe* ***any changes to the benefit plan offered to the new adult group.***
>
> *D. The rate certification and supporting documentation must describe any other material changes or adjustments to projected benefit costs.*

[Section III.2.B]

[1] https://www.ssa.gov/OP_Home/ssact/title11/1132.htm

[2] https://ecfr.io/Title-45/Part-95

[3] https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib051519.pdf

[4] For more information on the MLR requirements, please see: https://www.milliman.com/en/insight/new-cms-guidance-for-medicaid-managed-care-medical-loss-ratio-calculations