On June 25, 2021, CMS released the 2021-2022 Medicaid Managed Care Rate Development Guide (Guide).

Key Changes

1. Rate ranges permissible [Section I.A.viii]

CMS has deviated from their previous guidance on rate ranges, now allowing for actuaries to certify a range of capitation rates as opposed to a specific point estimate. Similar to previous requirements, the certification must document a number of items including [Section I.B.iv]:

* Differences in assumptions and/or methods between upper and lower bounds, including those values
* That the upper bound does not exceed the lower bound by more than 105%
* Criteria for paying at different points within the range
* Clear indication that the actuary is certifying rate ranges

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

The Guide also specifies procedures for rate and contract amendments for actuaries certifying rate ranges. A range of capitation rates certified as actuarially sound cannot be modified unless the changes within the rate range are less than 1.0% [Section I.A.ix.c]. For limited payment changes (1.5% for rates, 1.0% for rate ranges), 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 [Section I.A.ix.c.i-iii].

This change may impact many state programs who develop rate ranges, but were previously required to certify point estimates. To ease the CMS review process, some programs may continue to certify point estimates instead of upper and lower bounds.

1. Pass through payments [Section I.4.E]

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

* A footnote was added to clarify that pass-through payments are allowable for the transition period for states transitioning services and populations from a FFS delivery system to a managed care delivery system [Section I.4.E.i.b], without having to demonstrate that it had pass-through payments as defined in 42 CFR § 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 CFR § 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]
* 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.2.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.2.E.ii.b.iv.B]
  + Data, methodologies, and assumptions used to develop the calculations in 42 CFR § 438.6(d)(iii)(A), (B), or (C) [Section I.2.E.ii.d]

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 (aggregate or PMPM amount where 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[[1]](#footnote-1), as well as the letter to State Medicaid Directors regarding additional guidance on state directed payments[[2]](#footnote-2).
  + 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 entities.
* 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 pervious years’, including fiscal impact [Section I.4.E.ii.c.i.B]

Clarifying items

1. More explicit references to the Final Rule
   1. On November 9, 2020, CMS adopted the Final Medicaid and Children’s Health Insurance Program (CHIP) Managed Care Rule (“Final Rule”)[[3]](#footnote-3). Throughout the document, CMS has changed the language referring to the previous “Proposed Rule”, as well as other references to Sections within the Guide, to more explicitly refer to the federal rate development standards in 42 CFR § 438.4 through 438.7. The guidance itself is largely unchanged, but references are more along the lines of “in accordance with 42 CFR § 438” or similar language, as opposed to “guidance outlined in Section I.1.A”, for example.
2. Retroactive adjustments to capitation rates
   1. CMS clarified that if a retroactive adjustment to the capitation rates is necessary, they would accept either a new rate certification or a rate amendment. This 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 account for all differences from the most recently certified rates.
3. Health Insurance Providers Fee Repeal
   1. 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].
4. Minor changes in Appendix A
   1. 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:
      1. 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.
      2. Additional guidance for submission process
      3. Implementation of two year time limit on base data compliance
      4. Additional columns added to suggested table for non-benefit costs for amounts in previous rating period and percentage change between rating periods

1. <https://www.medicaid.gov/medicaid/managed-care/downloads/sdp-4386c-preprint-template.pdf> [↑](#footnote-ref-1)
2. <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21001.pdf> [↑](#footnote-ref-2)
3. <https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care> [↑](#footnote-ref-3)