**JHC Work**

# Key Changes

## 2. DOCUMENTATION OF COVID-19 IMPACT

CMS expects that states and their actuaries will evaluate how the capitation rates should 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 setting. States and their actuaries must also document in the rate certification the approach to address the impact of the COVID-19 PHE 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. In addition to allowing temporary flexibilities in rate development, CMS provided an example of a 2-sided risk corridor in the appendix of the Center for Medicaid & CHIP Services (CMCS) Informational Bulletin published May 14, 2020. Of note, CMS requires that states implementing state directed payments intended to mitigate the impacts of the COVID-19 PHE under this guidance must also implement a 2-sided risk mitigation strategy (such as a 2-sided risk corridor across all medical expenses) to provide protection for state and federal governments, as well as managed care plans. 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 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.
* 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)

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. 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 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 represents actual cost differences
* Financial impact on federal costs of the difference that varies by the rate of FFP

## 4. State Directed Payments

In accordance with 42 C.F.R. § 438.6(c)(2), all state directed payments must receive written prior approval from CMS. Review of rate certification cannot be finalized until all necessary written prior approvals are obtained. The prior rate development guide did not specify requirements for written prior approval. The state directed payment included in the rate certification must be consistent with the information in the approved preprint. 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. [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 specified table formats noted 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.

# Clarifying Items

## 2. 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]

If different capitation rates are being applied in a 12-month rating period, such as when the state is aligning contracts and rating periods, these should be documented on a 12-month basis.

## 4. 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.

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.

## 6. 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]

This confirms that no duplication of documentation is necessary in Section II and Section III.

## 8. Risk mitigation documentation for New Adult Group

CMS added language to stress that risk sharing arrangements must be documented in the contract and rate certification documents for the rating period prior to the start of the rating period, in accordance with 42 C.F.R § 438.6(b). 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 III.5.A]

CMS emphasizes that risk-sharing mechanism may not be added or modified after the start of the rating period.

**OUTLINE**

Key Changes

* Rate ranges permissible
* Documentation of COVID-19 impact
  + CMS recommending 2 sided risk mitigation strategy for all PHE impacted periods
* Added clarifying language on varying rates based on FFP
  + Stronger language
* Section I.4.D. Delivery System and Provider Payment Initiatives   
  🡪 Section I.4.D State Directed Payments
  + Directed payments to be reported with more documentation (i.e. descriptions in body of report AND prescribed tables)
  + Align with new preprint
* Section I.4.E Pass-Through Payments
  + Allowable pass through payments for states transitioning services or populations from FFS to managed care
  + Documentation of financing mechanism in alignment with new preprint  
    <https://www.medicaid.gov/medicaid/managed-care/downloads/sdp-4386c-preprint-template.pdf>

Clarifying Items

* 2020 Final Medicaid and CHIP Managed Care Rule
* More language about ensuring compliance with 42 CFR 438.4 and 7
* Removal of language around time periods other than 12 months
* De minimis requirement for retroactive adjustments, reconciliations
  + Retroactive rate adjustments can be submitted a either a rate amendment or new rate certification
* New footnotes pertaining to when a rate amendment AND contract amendment is required
* References to HIF are removed
* All general rate development standards outlined in Section I apply to Section II and Section III.
* Risk sharing mechanisms must be documented on the contract and rate certification prior to the start of rating period – may not be added after start of the rating period.
  + Harsher language likely due to enhanced FFP
* Additional clarifying language in Appendix A
  + Additional detail in non-benefit cost table