Analysis of 2022-2023 Medicaid Managed Care Rate Development Guide

For rating periods starting between July 1, 2022 and June 30, 2023

   
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# Executive Summary

On April 2, 2022, the Centers for Medicare & Medicaid Services (CMS) released the 2022-2023 Medicaid Managed Care Rate Development Guide (Guide) for rating periods starting between July 1, 2022 through June 30, 2023. In this paper, we provide a summary of the changes from the previous guide (2021-2022) 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.

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. Risk Mitigation Strategies
2. Appropriate Base Data
3. Risk Sharing Arrangement Documentation
4. State Directed Payments Documentation

Other notable items:

1. Compliance
2. COVID-19 Public Health Emergency (PHE) Assumptions
3. COVID-19 Public Health Emergency Approach
4. Pass-through Payments Effective July 1, 2022
5. Pass-through Payments to Hospitals Percentage Change

# Description of Appendices

## APPENDIX 1

Appendix 1 is a copy of the 2021-2022 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 2022-2023 Medicaid Managed Care Rate Development Guide, with green highlighting that indicates language that has been altered or added.

# Key Changes

## 1. Risk Mitigation Strategies [Footnote 6]

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. Examples of risk mitigation include (but are not limited to): reinsurance, stop loss limits, risk corridors, and a minimum MLR with a remittance. CMS will accept submissions of draft managed care contract actions that may not reflect final full rate development. 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 C.F.R. § 438.6(b)(1).

## 2. Appropriate Base Data [Footnote 20]

One detailed example was provided for how to meet the requirement for using the three **most recent and complete years** prior to the rating period. The example is:

[…] 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 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).

## 3. Risk Sharing Arrangement Documentation [Section I.4.C.ii]

Additional documentation is specified in the rate guide for an adequate description of risk sharing arrangements. This includes documentation that the risk-sharing arrangement is consistent with pricing assumptions used in capitation rate development, and that the risk-sharing arrangement will not result in a remittance/payment if calculated based on pricing assumptions used in capitation rate development.

## 4. State Directed Payments Documentation [Section I.4.D.ii]

State directed payments that do not require prior approval should be included in the documentation for this section. 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 C.F.R. § 438.6(a).

# Other Notable Items

## 1. Compliance [Footnote 4]

This footnote was added to indicate CMS will evaluate if addendums to the rate guide are necessary if any new federal requirements are implemented.

## 2. COVID-19 Public Health Emergency Assumptions [Section I.1.A.xii]

The actuary should describe the rationale for any applicable assumptions included or not included in the rate development related to the COVID-19 PHE. Differing from the previous rate setting guidance, actuaries must reflect on all applicable assumptions that are related to the COVID-19 PHE within the rate certification.

## 3. COVID-19 Public Health Emergency Approach [Section I.1.B.x]

Examples of certain assumptions were requested regarding the COVID-19 PHE. The added terminology here from the previous 2021-2022 guidance is centered around the detailed description and information regarding utilization, enrollment, deferred caseload, vaccinations, or treatments, etc. that must be added to the rate certification to show added support for the rate setting process.

Additional documentation must include a description of how the capitation rates account for the direct and indirect impacts of the COVID-19 PHE 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. Additionally, documentation must include 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.).

## 4. Pass-through Payments Effective July 1, 2022 [Footnotes 32 - 34]

Pass-through payments to hospitals must comply with the requirements of 42 C.F.R. § 438.6(d)(1). Pass-through payments are described as required payments that are not directly tied to utilization or outcomes based on utilization during the rating period of the contract. In accordance with 42 C.F.R. § 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 after July 1, 2022, as the transition period has ended.

## 5. Pass-through Payments to Hospitals Percentage Change [Section I.4.E.i.(c)]

In accordance with 42 C.F.R. § 438.6(d)(3), the aggregate pass-through payments to hospitals may not exceed the lesser of: (1) 50 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 C.F.R. § 438.6(d)(1)(i). This was changed from the lesser of 70 percent of the base amount from the 2021-2022 rate guide.



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