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. Rate 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

# 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.

A state planning to implement one, or multiple, risk mitigation strategies in a future rating period must submit a fully executed contract and rate certification prior to the start of the rating period. Before the rating period begins, CMS will accept drafts of the contract and the rate certification. The contract and/or the rate certification submitted to CMS in draft form must not be changed from that draft form before the fully executed documents are submitted to CMS at the beginning of the rating period 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 example, 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 on whether risk sharing parameters are consistent with pricing assumptions and will not result in a remittance/payment if calculated based on pricing assumptions used in capitation rate development. Actuaries will need to save all working documentation related to this provision above and create specific deliverable level information that can be submitted with the rate certification as an appendix.

## 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 (PHE) 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 everything that was conducted related to the COVID-19 PHE within the rate certification, instead of the previous guidance that merely wanted actuaries to evaluate the direct and indirect impacts that the COVID-19 PHE could have.

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

Examples of certain assumptions were requested regarding 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 public health emergency 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). 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). The difference in the new language from the 2021-2022 guidance is that the previous guidance said an aggregate pass-through payment to hospitals may not exceed the lesser of 70 percent of the base amount, and the new guidance is the aggregate pass-through payments to hospitals may not exceed the lesser of 50 percent of the base amount.

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.



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# Footnotes and Minor Changes in the 2022-2023 Medicaid Managed Care Rate Setting Guidance

## Footnote 4

## States must comply with all applicable federal statutory and regulatory requirements as well as guidance that impacts Medicaid managed care rate development. CMS will evaluate if addendums to this rate guide are necessary if any new federal requirements are implemented.

## 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. States must supply this information even if the state implemented the risk corridor (or other risk mitigation provision) in a prior rating period. Examples of risk mitigation include (but are not limited to): reinsurance, stop loss limits, risk corridors, and a minimum MLR with a remittance. For rating periods starting on or after January 1, 2021, submission of contract and rate certification documentation of the final risk mitigation arrangement(s) prior to the start of the rating period is required to meet the regulatory standard of documenting those arrangement(s) to CMS for the rating period prior to the start of the rating period. CMS will accept states’ submissions of draft managed care contract actions that are not officially executed and documentation from a state’s actuary that may not reflect final full rate development or is limited to a description of the risk sharing arrangement(s). States must submit both contract and rate certification documentation prior to the start of the rating period. 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).

## Footnote 20

## The preamble of the 2016 Medicaid and CHIP Managed Care Rule provides additional context around data requirements related to 42 C.F.R. 438.5(c)(2) per 81 FR 27573: “In § 438.5(c), we proposed standards for selection of appropriate base data. In paragraph (c)(1), we proposed that, for purposes of rate setting, states provide to the actuary Medicaid-specific data such as validated encounter data, FFS data (if applicable), and audited financial reports for the 3 most recent years completed prior to the rating period under development. In § 438.5(c)(2), we proposed that the actuary exercise professional judgment to determine which data is appropriate after examination of all data sources provided by the state, setting a minimum parameter that such data be derived from the Medicaid population or derived from a similar population and adjusted as necessary to make the utilization and cost data comparable to the Medicaid population for which the rates are being developed. We proposed that the data that the actuary uses must be from the 3 most recent years that have been completed prior to the rating period for which rates are being developed. For example, 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).”

## Section I.4.C.ii.

## Additional documentation on whether risk sharing parameters are consistent with pricing assumptions.

## Minor Wording Changes

## 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.

## Section I.1.B.x.

## Outlines additional detail requested in describing COVID rate setting assumptions.

## Section I.4.D.ii.

## Include state directed payments that do not require prior approval.

## Footnote 34.

## Language revised to indicate states cannot require pass-through payments for rating periods beginning July 1, 2022.