



2020-2021 Medicaid Managed Care Rate Development Guide

For Rating Periods Starting between July 1, 2020 and June 30, 2021¹

July 2, 2020

Introduction

The Centers for Medicare and Medicaid Services (CMS) is releasing the 2020-2021 Medicaid Managed Care Rate Development Guide for use in setting rates for rating periods starting between July 1, 2020 and June 30, 2021 for managed care programs subject to the actuarial soundness requirements in 42 CFR §438.4.² Consistent with the letter from the Administrator on March 14, 2017, and the Informational Bulletin released on June 30, 2017, CMS engaged in a comprehensive review of the managed care rules to prioritize beneficiary outcomes and more effective program management, culminating in release of a Notice of Proposed Rulemaking in November 2018, which included proposals to change the standards used to evaluate the actuarial soundness of Medicaid managed care plan capitation rates.³ Pending adoption of a final rule amending them, the regulations currently in place continue to govern the rate setting practices for Medicaid managed care plans that are outlined in this rate guide. This rate development guide

¹ This guide outlines federal standards for rate development and describes information required from states and their actuaries as part of actuarial rate certifications required under 42 CFR §438.7(a). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is OMB 0938-1148 (CMS-10398 #37). The time required to complete the information collection is estimated to average 4.5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

² Except as noted in the regulation text itself, all regulations related to rate setting at §§438.4, 438.5, 438.6 and 438.7 are applicable to the rating periods under contracts beginning on or after July 1, 2020. In addition, States must be compliant with provisions that impact rate development, including §§438.2, 438.3(c), 438.3(e), 438.8, 438.14, and 438.608(d).

³ The Notice of Proposed Rulemaking, Medicaid and Children's Health Insurance Plan (CHIP) Managed Care, was published in the Federal Register on November 14, 2018 (CMS-2408-P) (83 FR 57264).

builds upon the Medicaid Managed Care Rate Development Guide effective July 1, 2019 through June 30, 2020, and the experience of states and CMS in completing rate certifications and reviews.

This guide outlines federal standards for rate development and describes information required from states and their actuaries as part of actuarial rate certifications required under 42 CFR §438.7(a). The information outlined in this guide must be included within the rate certification in adequate detail to allow CMS (or its actuaries) to determine compliance with the applicable provisions of 42 CFR part 438, including that the data, assumptions, and methodologies used for rate development are consistent with generally accepted actuarial principles and practices and that the capitation rates are appropriate for the populations and services to be covered. CMS strives to review states' submissions of rate certification as efficiently as possible, and therefore, this guide describes the required standards for rate development in accordance with 42 CFR §438.5 and appropriate documentation for each submission in accordance with 42 CFR §438.7 to facilitate our review. The failure to include appropriate documentation may result in additional CMS questions and/or requests to obtain the information described in the guide as part of our review.

Additionally, as part of the CMS effort to review states' submissions of rate certification as efficiently as possible, CMS is implementing an accelerated rate review process. Appendix A contains additional information regarding this accelerated rate review process, specifically the criteria that a state must meet for the capitation rates to be eligible for an accelerated rate review and the rate development summary that states must provide in order to go through an accelerated rate review.

Section 1903(m)(2) of the Social Security Act and 42 CFR §438.4 require that capitation rates be actuarially sound, meaning that the capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care plan for the time period and the population covered under the terms of the contract. Such capitation rates are developed in accordance with 42 CFR §438.4(b). In applying the regulation standards, CMS will also use these three principles:

- the capitation rates are reasonable and comply with all applicable laws (statutes and regulations) for Medicaid managed care;
- the rate development process complies with all applicable laws (statutes and regulations) for the Medicaid program, including but not limited to eligibility, benefits, financing, any applicable waiver or demonstration requirements, and program integrity; and
- the documentation is sufficient to demonstrate that the rate development process meets the requirements of 42 CFR part 438 and generally accepted actuarial principles and practices.

There are three sections for this guide. The first section applies to all Medicaid managed care capitation rates. The second section outlines specific concepts that states and their actuaries must

consider when developing rates that include long-term services and supports (LTSS). The third section focuses on issues specific to new adult group capitation rates.

Most of the information discussed in this guide is or should be already part of ongoing actuarial work and program management in states. CMS provides the specific elements to be included in the rate certification to ensure consistency in the material that is submitted and transparency for what is included in federal review. Following CMS guidance included within this guide is more likely to result in a faster CMS review and reduce the number of questions. At this time, CMS does not prescribe a specific format for supplying this information in the rate certification although each of the relevant sections below must be discussed in sufficient detail in the rate certification.

Throughout this guide, CMS uses the term “rate certification” to mean both the letter (or attestation) from the actuary that specifically certifies that the rates are actuarially sound and meets the requirements of CMS regulation and any supporting documentation that relates the letter or attestation, including the actuarial report, other reports, letters, memorandums, other communications, and other workbooks or data. In practice, most states provide the information requested in the guide in the supporting documentation and not directly in the letter or attestation.

In accordance with 42 CFR §438.7(a), states must submit to CMS for review and approval all MCO, PIHP and PAHP rate certifications, concurrent with the review and approval of the contracts. CMS requests that states submit contract actions, rate certification(s) and associated supporting documentation as distinct documents within one submission rather than combining all materials into one electronic document. If multiple rate certifications are associated with the same contract action(s), CMS requests that states provide the supporting documentation that relates to each certification.

Section I. Medicaid Managed Care Rates

This section of the guidance is directed to all states setting Medicaid managed care rates that are subject to the actuarial soundness requirements in 42 CFR §438.4. The rate development and documentation standards outlined below are consistent with 42 CFR part 438 and relevant Actuarial Standards of Practice (ASOP). Actuaries are required to follow all Actuarial Standards of Practice; particularly relevant are ASOP 1 (Introductory Actuarial Standard of Practice); ASOP 5 (Incurred Health and Disability Claims); ASOP 12 (Risk Classification (for All Practice Areas)); ASOP 23 (Data Quality); ASOP 25 (Credibility Procedures); ASOP 41 (Actuarial Communications); ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies); and ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification). ASOP 49 is especially relevant because it focuses on the development of Medicaid managed care rates. The new applicable requirements under 42 CFR §438.4 are consistent with ASOP 49.

1. General Information

A. Rate Development Standards

- i. Rate certifications must be done for a 12-month rating period.⁴ CMS will consider a time period other than 12 months to address unusual circumstances. For example, CMS would approve a time period other than 12 months for the following reasons:
 - (a) when the state is trying to align program rating periods, which may require a rating period longer than one year (but less than two years); or
 - (b) when the state needs to make an amendment to the contract and the rates for an already approved rating period need to be adjusted accordingly.
- ii. In accordance with 42 CFR §438.4, 438.5, 438.6, and 438.7, an acceptable rate certification submission, as supported by the assurances from the state, includes the following items and information:
 - (a) a letter from the certifying actuary, who meets the requirements for an actuary in 42 CFR §438.2, who certifies that the final capitation rates meet the standards in 42 CFR §438.3(c), 438.3(e), 438.4, 438.5, 438.6, and 438.7.
 - (b) the final and certified capitation rates for all rate cells in accordance with 42 CFR §438.4(b)(4), and all regions (as applicable).⁵ Additionally, the contract must specify the final capitation rate(s) in accordance with 42 CFR §438.3(c)(1)(i).
 - (c) brief descriptions of the following information (to show that the actuary developing and/or certifying the rates has an appropriate understanding of the program for which he or she is developing rates):
 - (i) a summary of the specific state Medicaid managed care programs covered by the rate certification, including, but not limited to:
 - (A) the types and numbers of managed care plans included in the rate development (e.g., type means managed care organizations, prepaid inpatient health plans, or prepaid ambulatory health plans).
 - (B) a general description or list of the benefits that are required to be provided by the managed care plan or plans (e.g., types of medical services, behavioral health or mental health services, long-term care services, etc.), particularly noting any benefits that are carved out of

⁴ Per 42 CFR §438.2, “rating period” means a period of 12 months selected by the state for which the actuarially sound capitation rates are developed and documented in the rate certification.

⁵ Actuaries must certify specific rates for each rate cell in accordance with 42 CFR §438.4(b)(4) and 438.7(c), and it is no longer permissible to certify rate ranges. However, 42 CFR §438.7(c)(3) allows states to increase or decrease the capitation rate per rate cell up to 1.5 percent without submitting a revised rate certification.

the managed care program or that are new to the managed care program in that rating period covered.

(C) the areas of the state covered by the managed care rates and approximate length of time the managed care program has been in operation.

(ii) the rating period covered by the rate certification.

(iii) the Medicaid population(s) covered through the managed care program(s) to which the rate certification applies.

(iv) any eligibility or enrollment criteria that could have a significant influence on the specific population to be covered within the managed care program (e.g., the definition of medically frail, or if enrollment in managed care plans is voluntary or mandatory).

(v) a summary of the special contract provisions related to payment that, per 42 CFR §438.6, are included within rate development (e.g. risk-sharing mechanisms, incentive arrangements, withhold arrangements, state-directed delivery system reform and provider payment initiatives,⁶ pass-through payments, and payments to MCOs and PIHPs for enrollees that are a patient in an Institution of Mental Disease (IMD)).

(vi) if the state determines that a retroactive adjustment to the capitation rates is necessary, these retroactive adjustments must be certified by an actuary in a revised rate certification and submitted as a contract amendment in accordance with 42 CFR §438.7(c)(2). The revised rate certification must:

(A) describe the rationale for the adjustment; and

(B) the data, assumptions and methodologies used to develop the magnitude of the adjustment.

iii. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations.

iv. Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments from any other rate cell.

⁶ State direction of managed care plan expenditures under the contract (e.g., value-based purchasing arrangements, multi-payer initiatives, quality/performance incentive programs, and all fee schedules) must meet the requirements in 42 CFR §438.6(c) and receive prior approval before implementation. In order to ensure that States can have these directed payment arrangements reviewed and approved prior to developing rates, CMS has a separate process for submitting payment arrangements under 42 CR §438.6(c).

- v. The effective dates of changes to the Medicaid managed care program (including eligibility, benefits, payment rate requirements, incentive programs, and program initiatives) must be consistent with the assumptions used to develop the capitation rates.
- vi. Capitation rates must be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio, as calculated under 42 CFR §438.8, of at least 85 percent for the rate year. The capitation rates may be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard greater than 85 percent, as calculated under 42 CFR §438.8, as long as the capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs. Under §438.8(j), the state may choose to impose remittance provisions related to this medical loss ratio. The terms and conditions of any remittance must clearly be outlined in the rate certification and demonstrate compliance with 438.8(c), which requires a State, that elects to mandate a minimum MLR for its MCOs, PIHPs, or PAHPs, to use a minimum MLR equal to or higher than 85 percent.⁷
- vii. As part of CMS's determination of whether or not the rate certification submission and supporting documentation adequately demonstrate that the rates were developed using generally accepted actuarial practices and principles, CMS will consider whether the submission demonstrates the following:
 - (a) all adjustments to the capitation rates, or to any portion of the capitation rates, must reflect reasonable, appropriate, and attainable costs in the actuary's judgment and must be included in the rate certification.
 - (b) adjustments to the rates that are performed outside of the rate setting process described in the rate certification are not considered actuarially sound under 42 CFR §438.4. Therefore, the rates will not be considered actuarially sound if adjustments are made outside of the rate setting process described in the rate certification.
 - (c) consistent with 42 CFR §438.7(c), the final contracted rates in each cell must match the capitation rates in the rate certification. This is required in total and for each and every rate cell.
- viii. Rates must be certified for all time periods in which they are effective, and a certification must be provided for rates for all time periods. Rates from a previous rating period cannot be used for a future time period without an actuarial certification of the rates for the new rating period.

⁷ On May 15, 2019, the Center for Medicaid & CHIP Services (CMCS) published a [CMCS Informational Bulletin](#) outlining Medical Loss Ratio requirements related to third-party vendors.

- ix. Procedures for rate certifications for rate and contract amendments, include:
- (a) if a state intends to claim Federal financial participation (FFP) for capitation rates, the state must comply with the time limit for filing claims for FFP specified in section 1132 of the Social Security Act and implementing regulations at 45 CFR part 95. States should timely submit rate certifications to CMS to help mitigate timely filing concerns.
 - (b) the state must submit a revised rate certification when the rates change, except for changes permitted in 42 CFR §438.7(c)(3).
 - (c) for contract amendments that do not affect the rates (except for changes permitted in 42 CFR §438.7(c)(3)), CMS does not require a rate amendment from the state. However, if the contract amendment revises the covered populations, services furnished under the contract or other changes that could reasonably change the rate development and rates, the state and its actuary must provide supporting documentation indicating the rationale as to why the rates continue to be actuarially sound in accordance with 42 CFR §438.4.
 - (d) there are several circumstances when CMS would not require a rate amendment:
 - (i) the state may increase or decrease capitation rate per rate cell up to 1.5 percent range, in accordance with 42 CFR §438.7(c)(3).
 - (ii) a state applies risk scores to the capitation rates paid to the plans under a risk adjustment methodology described in the rate certification for that rating period and contract, in accordance with 42 CFR §438.7(b)(5)(iii).
 - (e) any time a rate changes for any reason other than application of an approved payment term (e.g., risk adjustment methodology), which was included in the initial managed care contract, the state must submit a contract amendment to CMS, even if the rate change does not need a rate amendment.
 - (f) State Medicaid program features are sometimes invalidated by courts of law, or by changes in federal statutes, regulations or approvals. A state must submit a rate amendment adjusting capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. The rate amendment must take into account the effective date of the loss of program authority.

B. Appropriate Documentation

- i. States and their actuaries must document all the elements described within their rate certification to provide adequate detail that CMS is able to determine whether or not the regulatory standards are met. In evaluating the rate certification, CMS will look to the reasonableness of the information contained in the rate certification for the purposes of rate development and may require additional information or

documentation as necessary to review and approve the rates. States and their actuaries must ensure that the following elements are properly documented:

- (a) data used, including citations to studies, research papers, other states' analyses, or similar secondary data sources.
 - (b) assumptions made, including any basis or justification for the assumption.
 - (c) methods for analyzing data and developing assumptions and adjustments.
- ii. CMS understands that there are instances where actuaries develop ranges around various assumptions and adjustments. We believe this is a valid and appropriate approach to aid in the development and selection of the final assumptions that underlie the certified capitation rates, but note that actuaries must certify specific rates for each rate cell in accordance with 42 CFR §438.4(b)(4) and 438.7(c), and it is not permissible to certify rate ranges. Therefore, the actuary must be responsible for all assumptions and adjustments underlying the certified capitation rates, and the certification must disclose and support the specific assumptions that underlie the certified rates for each rate cell, including the magnitude and narrative support for each specific assumption or adjustment that underlies the certified rates for each rate cell. To the extent assumptions or adjustments underlying the capitation rates varies between managed care plans, the certification must also describe the basis for this variation.
- iii. The rate certification must include an index that identifies the page number or the section number for each item described within this guidance. In cases where not all sections of this guidance are relevant for a particular rate certification (i.e., an amended certification that adds a new benefit for part of the year), inapplicable sections of the guidance must be included and marked as "Not Applicable" in the index. CMS prefers that the rate certification include an index and also follow the structure of this guidance.
- iv. There are services, populations, or programs for which the state receives a different federal medical assistance percentage (FMAP) than the regular state FMAP. In those cases, the portions or amounts of the costs subject to the different FMAP must be separately shown as part of the rate certification to the extent possible.
- v. CMS requests that states that operated the managed care program or programs covered by the rate certification in previous rating periods provide:
- (a) A comparison to the final certified rates in the previous rate certification. For the first rate certification for a rating period, this should be a comparison to the prior rating period's rates or rate ranges. For rate certifications that revise or amend rates in a rating period, this should be a comparison to the latest certified rates for

the rating period. If there are large or negative changes in rates from the previous year, the actuary must describe what is leading to these differences.

- (b) A description of any other material changes to the capitation rates or the rate development process compared to the prior rating period (or compared to the latest rate certification for rate certifications that amend rates) not otherwise addressed in the other sections of this guidance.
- vi. The rate certification should include a list of known amendments that will be provided to CMS in the future, when the state expects the amendments will be submitted to CMS, and why the current certification cannot account for changes that are anticipated to be made to the rates.

2. Data

A. Rate Development Standards

- i. In accordance with 42 CFR §438.5(c), states and actuaries must follow rate development standards related to base data, including:
 - (a) states must provide all the validated encounter data and/or fee-for-service (FFS) data (as appropriate) and audited financial reports (as defined in see §438.3(m)) that demonstrates experience for the populations to be served by the health plan to the state's actuary developing the capitation rates for at least the three most recent and complete years prior to the rating period.
 - (b) states and their actuaries must use the most appropriate base data, from the three most recent and complete years prior to the rating period, for developing capitation rates.
 - (c) base data must be derived from the Medicaid population, or, if data on the Medicaid population is not available, derived from a similar population and adjusted to make the utilization and price data comparable to data from the Medicaid population.
 - (d) states that are unable to develop rates using data that is no older than from the three most recent and complete years prior to the rating period may request approval for an exception as follows:
 - (i) this request should be submitted by the state as soon as the actuary starts developing the rate certification and makes a determination that base data will not comply with 42 CFR §438.5(c)(1)-(2).
 - (ii) the request must describe why an exception is necessary and describe the actions the state intends to take to come into compliance with those requirements.

(iii) the request must also describe the state's proposed corrective action plan outlining how the state will come into compliance with the base data standards per 42 CFR §438.5(c) no later than two years from the rating period for which the deficiency is identified.

B. Appropriate Documentation

- i. In accordance with 42 CFR §438.7(b)(1), the rate certification must include:
 - (a) a description of base data requested and used for the rate setting process, including:
 - (i) a summary of the base data that was requested by the actuary.
 - (ii) a summary of the base data that was provided by the state.
 - (iii) an explanation of why any base data requested was not provided by the state.
 - ii. The rate certification, as supported by the assurances from the state, must thoroughly describe the data used to develop the capitation rates, including:
 - (a) a description of the data, including:
 - (i) the types of data used, which may include, but is not limited to: fee-for-service claims data; managed care encounter data; health plan financial data; information from program integrity audits; or other Medicaid program data.
 - (ii) the age or time periods of all data used.
 - (iii) the sources of all data used (e.g., State Medicaid Agency; other state agencies; health plans; or other third parties).
 - (iv) if a significant portion of the benefits under the contract with the managed care entity are provided through arrangements with subcontractors that are also paid on a capitated basis (or subcapitated arrangements), a description of the data received from the subcapitated plans or providers; or, if data is not received from the subcapitated plans or providers, a description of how the historical costs related to subcapitated arrangements were developed or verified.
 - (b) information related to the availability and the quality of the data used for rate development, including:
 - (i) the steps taken by the actuary or by others (e.g., State Medicaid Agency; health plans; external quality review organizations; financial auditors; etc.) to validate the data, including:
 - (A) completeness of the data.
 - (B) accuracy of the data.

- (C) consistency of the data across data sources.
 - (ii) a summary of the actuary's assessment of the data.
 - (iii) any concerns that the actuary has over the availability or quality of the data.
- (c) a description of how the actuary determined what data was appropriate to use for the rating period, including:
 - (i) if fee-for-service claims or managed care encounter data are not used (or are not available), this description should include an explanation of why the data used in rate development is appropriate for setting capitation rates for the populations and services to be covered.
 - (ii) if managed care encounter data was not used in the rate development, this description should include an explanation of why encounter data was not used as well as any review of the encounter data and the concerns identified which led to not including the encounter data.
 - (d) if there is any reliance or use of a data book in the rate development, the details of the template and relevant instructions used in the data book.
- iii. The rate certification, as supported by the assurances from the state, must thoroughly describe any significant adjustments, and the basis for the adjustments, that are made to the data, including but not limited to adjustments for:
 - (a) the credibility of the data.
 - (b) completion factors.
 - (c) errors found in the data.
 - (d) changes in the program between the time period from which the data is obtained and the rating period (e.g., changes in the population covered; changes in benefits or services; changes to payment models or reimbursement rates to providers; or changes to the structure of the managed care program).
 - (e) exclusions of certain payments or services from the data.

3. Projected Benefit Costs and Trends

A. Rate Development Standards

- i. Final capitation rates must be based only upon the services allowed in 42 CFR §438.3(c)(1)(ii) and 438.3(e).
- ii. Variations in the assumptions used to develop the projected benefit costs for covered populations must be based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations.

- iii. In accordance with 42 CFR §438.5(d), each projected benefit cost trend assumption must be reasonable and developed in accordance with generally accepted actuarial principles and practices. Trend assumptions must be developed primarily from actual experience of the Medicaid population or from a similar population and include consideration of other factors that may affect projected benefit cost trends through the rating period.
- iv. If the projected benefit costs include costs for in-lieu-of services defined at 42 CFR §438.3(e)(2) (i.e., substitutes for State Plan services or settings), the utilization and unit costs of the in-lieu-of services must be taken into account in developing the projected benefit costs of the covered services (as opposed to utilization and unit costs of the State plan services or settings), unless a statute or regulation explicitly requires otherwise. The costs of an IMD as an in-lieu-of-service must not be used in rate development. See Section I, item 3.A.v of this guide.
- v. When IMDs are used to provide in-lieu-of services, states may make a monthly capitation payment to an MCO or PIHP under a “risk contract” (as defined in 42 CFR §438.2) for an enrollee age 21 to 64 receiving inpatient treatment in an IMD (as defined in 42 CFR §435.1010) for a short-term stay of no more than 15 days during the period of the monthly capitation payment in accordance with 42 CFR §438.6(e). In this case, when developing the projected benefit costs for these services, the actuary must use the unit costs of providers delivering the same services included in the State Plan, as opposed to the unit costs of the IMD services. The actuary may use the utilization of the services provided to an enrollee in an IMD in developing the utilization component of projected benefit costs. The data used for developing the projected benefit costs for these services must not include:
 - (a) costs associated with an IMD stay of more than 15 days.
 - (b) any other costs for any services delivered during the time an enrollee is in an IMD for more than 15 days.

B. Appropriate Documentation

- i. The rate certification must clearly document the final projected benefit costs by relevant level of detail (e.g., rate cell, or aligned with how the state makes payments to the plans).
- ii. The rate certification and supporting documentation must describe the development of the projected benefit costs included in the capitation rates, including:
 - (a) a description of the data, assumptions, and methodologies used to develop the projected benefit costs and, in particular, all significant and material items in developing the projected benefit costs.

- (b) any material changes to the data, assumptions, and methodologies used to develop projected benefit costs since the last rate certification must be described.
 - (c) the amount of overpayments to providers and a description of how the state accounted for this in rate development. *See* §438.608(d).
- iii. The rate certification and supporting documentation must include a section on projected benefit cost trends (i.e. an estimate the projected change in benefit costs from the historical base data period(s) to the rating period of the rate certification) in accordance with 42 CFR §438.7(b)(2).
- (a) this section must include:
 - (i) any data used or assumptions made in developing projected benefit cost trends, including a description of the sources of those data and assumptions.
 - (A) citations for the data and sources used to develop the assumptions should be included whenever possible, particularly when published articles, reports, and sources other than actual experience from the Medicaid population are used.
 - (B) the description should state whether the trend is developed primarily with actual experience from the Medicaid population or provide rationale for the experience from a similar population that is utilized, and consideration of other factors expected to impact trend.
 - (ii) the methodologies used to develop projected benefit trends.
 - (iii) any comparisons to historical benefit cost trends, or other program benefit cost trends, that were analyzed as part of the development of the trend for the rating period of the rate certification.
 - (iv) documentation supporting the chosen trend rates and explanation of outlier and negative trends.
 - (b) this section must include the projected benefit cost trends separated into components, specifically:
 - (i) the projected benefit cost trends should be separated into:
 - (A) changes in price (i.e., pricing differences due to different provider reimbursement rates or payment models); and
 - (B) changes in utilization (i.e., differences in the amount, duration, or mix of benefits or services provided).

- (ii) if the actuary did not develop the projected benefit cost trends using price and utilization components, the actuary should describe and justify the method(s) used to develop projected benefit cost trends.
 - (iii) the projected benefit cost trends may include other components as applicable and used by the actuary in developing rates (e.g., changes in location of service delivery; the effect of utilization or care management on projected benefit cost trends; regional differences or variations).
- (c) variations in the projected benefit cost trends must be explained. Projected benefit cost trends may vary by:
- (i) Medicaid populations.
 - (ii) rate cells.
 - (iii) subsets of benefits within a category of services (e.g., specialty vs. non-specialty drugs).
- (d) any other material adjustments to projected benefit cost trends must be described in accordance with 42 CFR §438.7(b)(4), including:
- (i) a description of the data, assumptions, and methodologies used to determine each adjustment.
 - (ii) the cost impact of each material adjustment.
 - (iii) where in the rate setting process the material adjustment was applied.
- (e) any other adjustments to projected benefit costs trends must be listed. CMS also requests the following detail about non-material adjustments:
- (i) the impact of managed care on the utilization and the unit costs of health care services.
 - (ii) changes to projected benefit costs trend in the rating period outside of regular changes in utilization or unit cost of services.
- iv. If the projected benefit costs include additional services deemed by the state to be necessary to comply with the mental health parity standards in 42 CFR Part 438, subpart K⁸ as required by 42 CFR §438.3(c)(1)(ii), the following must be described:
- (a) the categories of service that contain these additional services necessary for parity.
 - (b) the percentage of cost that these services represent in each category of service.

⁸ Part 438, subpart K applies the parity standards of the Mental Health Parity and Addiction Equity Act to Medicaid managed care plans consistent with the requirements of section 1832 of the Act.

- (c) how these services were taken into account in the development of the projected benefit costs, and if this approach was different than that for any of the other services in the categories of service.
 - (d) an assurance that the payment represents a payment amount that is adequate to allow the MCO, PIHP or PAHP to efficiently deliver covered services to Medicaid-eligible individuals in a manner compliant with contractual requirements.
- v. For in-lieu-of services defined at 42 CFR §438.3(e)(2) (i.e., substitutes for State Plan services), the following information must be provided and documented:
- (a) the categories of covered service that contain in-lieu-of-services.
 - (b) the percentage of cost that in-lieu-of services represent in each category of service.
 - (c) how the in-lieu-of services were taken into account in the development of the projected benefit costs, and if this approach was different than that for any of the other services in the categories of service.
 - (d) for inpatient psychiatric or substance use disorder services provided in an IMD setting, rate development must comply with the requirements of 42 CFR §438.6(e) and the data and assumptions utilized should be described in the rate certification. The costs of an IMD as an in-lieu-of-service must not be used in rate development. See Section I, item 3.A.v of this guide.
- vi. The rate certification must describe how retrospective eligibility periods are accounted for in rate development, including but not limited to:
- (a) the managed care plan's responsibility to pay for claims incurred during the retroactive eligibility period.
 - (b) how the claims information are included in the base data.
 - (c) how the enrollment or exposure information is included in the base data.
 - (d) how the capitation rates are adjusted to reflect the retroactive eligibility period, and the assumptions and methodologies used to develop those adjustments.
- vii. The rate certification must clearly document the impact on projected costs for all material changes to covered benefits or services since the last rate certification, including, but not limited to:
- (a) more or fewer state plan benefits covered by Medicaid managed care.
 - (b) any recoveries of overpayments made to providers by health plans in accordance with 42 CFR §438.608(d).

- (c) requirements related to payments from health plans to any providers or class of providers.
 - (d) requirements or conditions of any applicable waivers.
 - (e) requirements or conditions of any litigation to which the state is subjected.
- viii. For each change related to covered benefits or services, the rate certification must include an estimated impact of the change on the amount of projected benefit costs and a description of the data, assumptions, and methodologies used to develop the adjustment.
- (a) any change determined by the actuary to be non-material can be grouped with other non-material changes and described within the rate certification, provided that:
 - (i) the rate certification includes a list of all non-material adjustments used in the rate development process.
 - (ii) the actuary must give a description of why the changes were not considered material and how they were aggregated into a single adjustment.
 - (iii) the rate certification provides a description of where in the rate setting process the adjustments were applied.
 - (iv) The rate certification documents the aggregate cost impact of all non-material adjustments.

4. Special Contract Provisions Related to Payment

A. Incentive Arrangements

i. Rate Development Standards

- (a) the rate certification and supporting documentation must describe any incentives included in the contract between the state and the health plans. An incentive arrangement, as defined in 42 CFR §438.6(a), is any payment mechanism under which a health plan may receive additional funds over and above the capitation rate it was paid for meeting targets specified in the contract.
 - (i) the rate certification must include documentation that the total payments under the incentive arrangement (i.e., capitation rate payments plus incentive payments) will not exceed 105 percent of the approved capitation payments under the contract that are attributable to the enrollees or services covered by the incentive arrangements as required in 42 CFR §438.6(b)(2).

ii. Appropriate Documentation

- (a) the rate certification must include a description of the incentive arrangement. An adequate description includes at least:
 - (i) the time period of the incentive arrangement (which must not be longer than the rating period).
 - (ii) the enrollees, services, and providers covered by the incentive arrangement.
 - (iii) the purpose of the incentive arrangement (e.g. specified activities, targets, performance measures, or quality-based outcomes, etc.).
 - (iv) confirmation that the total payments under the incentive arrangements will not exceed 105 percent of the capitation payments.
 - (v) a description of any effect that each incentive arrangement has on the development of the capitation rates.

B. Withhold Arrangements

i. Rate Development Standards

- (a) the rate certification and supporting documentation must describe any withhold arrangements in the contract between the state and the health plans. As defined in 42 CFR §438.6(a), a withhold arrangement is any payment mechanism under which a portion of a capitation rate is withheld from an MCO, PIHP, or PAHP and a portion of or all of the withheld amount will be paid to the MCO, PIHP, or PAHP for meeting targets specified in the contract.
 - (i) the targets for a withhold arrangement are distinct from general operational requirements under the contract.
 - (ii) arrangements that withhold a portion of a capitation rate for noncompliance with general operational requirements are a penalty and not a withhold arrangement.
- (b) in accordance with 42 CFR §438.6(b)(3), the capitation payment(s) minus any portion of the withhold that is not reasonably achievable must be actuarially sound.

ii. Appropriate Documentation

- (a) the rate certification must include a description of the withhold arrangement. An adequate description includes at least the following:
 - (i) the time period of the withhold arrangement (which must not be longer than the rating period).
 - (ii) the enrollees, services, and providers covered by the withhold arrangement.

- (iii) the purpose of the withhold arrangement (e.g. specified activities, targets, performance measures, or quality-based outcomes, etc.).
 - (iv) a description of the total percentage of the certified capitation rates being withheld through withhold arrangements.
 - (v) an estimate of the percentage of the withheld amount in a withhold arrangement that is not reasonably achievable and the basis for that determination, including the data, assumptions, and methodologies used to make this determination.
 - (vi) a description of how the total withhold arrangement, achievable or not, is reasonable and takes into consideration the health plan's financial operating needs accounting for the size and characteristics of the populations covered under the contract, as well as the health plan's capital reserves as measured by the risk-based capital level, months of claims reserve, or other appropriate measure of reserves.
 - (vii) a description of any effect that each withhold arrangement has on the development of the capitation rates.
- (b) the actuary must certify capitation payment(s) minus any portion of the withhold that is not reasonably achievable as actuarially sound.

C. Risk-Sharing Mechanisms

i. Rate Development Standards

- (a) in accordance with 42 CFR §438.6(b), if the state utilizes risk-sharing mechanisms with its health plan(s), such as reinsurance, risk corridors, or stop-loss limits, these arrangements must be described in the contract(s) and must be developed in accordance with §438.4, the rate development standards in §438.5, and generally accepted actuarial principles and practices.
- (b) the rate certification and supporting documentation must describe any risk mitigation that may affect the rates or the final net payments to the health plan(s) under the applicable contract.

ii. Appropriate Documentation

- (a) the rate certification and supporting documentation must include a description of any other risk-sharing arrangements, such as a risk corridor or a large claims pool. An adequate description of these includes at least the following:
 - (i) a rationale for the use of the risk sharing arrangement.
 - (ii) a detailed description of how the risk-sharing arrangement is implemented.

- (iii) a description of any effect that the risk-sharing arrangements have on the development of the capitation rates.
 - (iv) documentation demonstrating that the risk-sharing mechanism has been developed in accordance with generally accepted actuarial principles and practices.
- (b) if the contract includes a remittance/payment requirement for being below/above a specified medical loss ratio (MLR), the rate certification and supporting documentation must include a description of this MLR arrangement. An adequate description includes at least the following:
- (i) the methodology used to calculate the medical loss ratio.
 - (ii) the formula for calculating a remittance/payment for having a medical loss ratio below/above the minimum requirements.
 - (iii) any other consequences for a remittance/payment for a medical loss ratio below/above the minimum requirements.
- (c) if the contract has reinsurance requirements, the rate certification and supporting document must include a description of the reinsurance requirements. An adequate description includes at least the following:
- (i) a detailed description of any reinsurance requirements under the contract associated with the rate certification, including the reinsurance premiums and any relevant historical reinsurance experience.
 - (ii) identification of any effect that the reinsurance requirements have on the development of the capitation rates.
 - (iii) documentation that the reinsurance mechanism has been developed in accordance with generally accepted actuarial principles and practices.
 - (iv) if the actuary develops the reinsurance premiums, a description of how the reinsurance premiums were developed, including the data, assumptions and methodology used.

D. Delivery System and Provider Payment Initiatives

i. Rate Development Standards

- (a) consistent with 42 CFR §438.6(c), states may utilize delivery system and provider payment initiatives, including requiring managed care plans to:⁹
- (i) implement value-based purchasing models for provider reimbursement, such as pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services.
 - (ii) participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.
 - (iii) adopt a minimum fee schedule for network providers that provide a particular service under the contract.
 - (iv) provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract.
 - (v) adopt a maximum fee schedule for network providers that provide a particular service under the contract, so long as the health plan retains the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.
- (b) The state's rate certification for the applicable period must address how each payment arrangement approved by CMS under 42 CFR 438.6(c) is reflected in the payments to the managed care plan from the state. Such payment arrangements can be incorporated into the base capitation rates as an adjustment to the rate or addressed through a separate payment term. When the payment arrangement is addressed through a separate payment term, CMS's expectations are as follows:
- (i) documentation related to the payment term will be included in the initial rate certification as outlined in Section I, Item 4.D.ii.a.iii of the guide.
 - (ii) when a material portion of the total capitation payment to the managed care plan for any rate cell is for directed payments addressed through separate payment terms, an estimate of the magnitude of that portion of the payment on a PMPM basis for each rate cell (CMS recognizes that this is an estimate, and that the state will provide the final figures after the payment has been made).

⁹ All state directed payments in Medicaid managed care contracts that are authorized under 42 CFR §438.6(c) must be based on the utilization and delivery of services to Medicaid beneficiaries covered under the contract. These payments must be directed equally, and using the same terms of performance across a class of providers. Further details on these payments are described in §438.6(c) and the CMCS Informational Bulletin, dated November 2, 2017: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib11022017.pdf>. Payments permitted under 42 CFR §438.6(d) must be addressed as noted in section E.

(iii) after the rating period is complete and the state makes the payment consistent with the contract and as reflected in the initial rate certification, the state must submit documentation to CMS that incorporates the total amount of the payment into the rate certification's rate cells consistent with the distribution methodology described in the initial rate certification, as if the payment information (e.g., providers receiving the payment, amount of the payment, utilization that occurred, enrollees seen, etc.) had been known when the rates were initially developed.

(iv) please note, if the total amount of the payment or distribution methodology is changed from the initial rate certification, CMS expects the state to submit a rate amendment for the rating period, and clearly describe the magnitude of and the reason for the change.

ii. Appropriate Documentation

(a) the rate certification and supporting documentation must include a description of each delivery system and provider payment initiative. The documentation needed depends on which approach the state has used to incorporate the payment into its rate certification. Please provide the following information for each delivery system and provider payment initiative:

(i) a brief description of the delivery system and provider payment initiative(s) included in the rates for this rating period, including:

(A) the type of directed payment arrangement (minimum fee schedule, maximum fee schedule, bundled payment, etc.).

(B) a brief description (e.g. minimum fee schedule is set at \$x as approved in the Medicaid state plan, minimum fee schedule is set at y% of Medicare, etc.).

(ii) if a payment will be incorporated into the rate certification in the base capitation rates as a rate adjustment, then the following information should be included in the state's rate certification (please include this information for each separate directed payment arrangement):

(A) an indication of which rate cells were affected by the directed payment arrangement.

(B) the impact the directed payment has on the rates, for each rate cell.

(C) a description of how the payment arrangement is reflected in the certified capitation rates. To the extent an adjustment is applied to account for the impact of the payment arrangement or changes to the payment arrangement from the base data period, the actuary should provide a

description of the data, assumptions, and methodologies used to develop the adjustment.

- (D) an indication that the payment is being made under an approved §438.6(c) payment arrangement in a manner that is consistent with the pre-print (including any correspondence between the state and CMS regarding the pre-print) reviewed by CMS. To the extent the payment arrangement has not been approved by CMS before the actuary certifies the capitation rates, this should be noted in the certification and the payment arrangement that is under review should still be accounted for in rate development. In this case, the actuary should also provide an indication that the payment arrangement is accounted for in a manner consistent with the pre-print that is under CMS review. If the preprint has not yet been submitted to CMS for review, the certification should indicate when the preprint will be submitted to CMS.
- (E) if implementing a maximum fee schedule, the actuary should explain if there are any instances in the base data where the plans paid above the maximum fee schedule and how the actuary determined that it was reasonable to assume that the plans that currently pay above the maximum fee schedule will be able to lower their reimbursement rates consistent with the maximum fee schedule requirement. The actuary should also explain whether there are any exemptions to the maximum fee schedule which allow for plans to pay above the maximum fee schedule during the rating period and how these exemptions were considered in rate development.
- (iii) if the payment will be incorporated into the initial rate certification as a separate payment term, then the following information should be included in the state's rate certification (please include this information for each separate directed payment arrangement):
 - (A) the aggregate amount of the payment applicable to the rate certification.
 - (B) an explicit statement from the actuary that he or she certifies the amount of the separate payment term disclosed in the certification (i.e. the amount in Section I, Item 4.D.ii.a.iii.A).
 - (C) the provider types that will be receiving the payment.
 - (D) the distribution methodology.
 - (E) an estimate of the magnitude of the payment on a PMPM basis for each rate cell (CMS recognizes that this is an estimate, and that the state will provide the final figures after the payment has been made).

(F) an indication that the payment is being made under an approved §438.6(c) payment arrangement in a manner that is consistent with the pre-print (including correspondence between the state and CMS regarding the pre-print) reviewed by CMS. To the extent the payment arrangement has not been approved by CMS before the actuary certifies the capitation rates, this should be noted in the certification and the payment arrangement that is under review should still be accounted for in rate development. In this case, the actuary should also provide an indication that the payment arrangement is accounted for in a manner consistent with the pre-print that is under CMS review. If the preprint has not been submitted to CMS for review, the certification should indicate when the preprint will be submitted to CMS.

(G) a statement that after the rating period is complete the state will submit (to CMS) documentation that incorporates the total amount of the payment into the rate certification's rate cells consistent with the distribution methodology described in the initial rate certification, and as if the payment information (e.g., providers receiving the payment, amount of the payment, utilization that occurred, enrollees seen, etc.) had been fully known when the rates were initially developed.

- (b) The rate certification and supporting documentation must confirm that there are not any additional directed payments in the program that are not addressed in the certification.
- (c) The rate certification and supporting documentation must confirm that there are not any requirements regarding the reimbursement rates the plans must pay to any providers unless specifically specified in the certification as a directed payment or authorized under applicable law, regulation, or waiver.

E. Pass-Through Payments

i. Rate Development Standards

- (a) a pass-through payment, as defined in 42 CFR §438.6(a), is any amount required by the state to be added to the contracted payment rates, and considered in calculating the actuarially sound capitation rate, between MCOs, PIHPs, or PAHPs and hospitals, physicians, or nursing facilities that is not for one of the following purposes:^{10,11}

¹⁰ States may not require health plans to make pass-through payments other than those permitted to network providers that are hospitals, physicians, and nursing facilities in accordance with 42 CFR §438.6(d)(1).

¹¹ Pass-through payments are most easily identified as required payments that are not directly tied to utilization or outcomes based on utilization during the rating period of the contract.

- (i) a specific service or benefit provided to a specific enrollee covered under the contract;
 - (ii) a provider payment methodology permitted under 42 CFR §438.6(c)(1)(i) through (iii) for services and enrollees covered under the contract;
 - (iii) a subcapitated payment arrangement for a specific set of services and enrollees covered under the contract;
 - (iv) Graduate Medical Education (GME) payments; or
 - (v) Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) wrap around payments.
- (b) pass-through payments are allowed for transition periods as outlined in 42 CFR §438.6(d). In order to use a transition period, a state must demonstrate that it had pass-through payments for hospitals, physicians, or nursing facilities, as defined in 42 CFR §438.6(d)(1)(i), in:¹²
- (i) managed care contract(s) and rate certification(s) for the rating period that includes July 5, 2016, and were submitted for CMS review and approval on or before July 5, 2016; or
 - (ii) if the managed care contract(s) and rate certification(s) for the rating period that includes July 5, 2016 had not been submitted to CMS on or before July 5, 2016, the managed care contract(s) and rate certification(s) for a rating period before July 5, 2016 that had been most recently submitted for CMS review and approval as of July 5, 2016.
- (c) pass-through payments to hospitals must comply with the requirements of 42 CFR §438.6(d).
- (i) in accordance with 42 CFR §438.6(d)(3), the aggregate pass-through payments to hospitals may not exceed the lesser of: (1) 70 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 CFR §438.6(d)(1)(i).
 - (ii) in accordance with 42 CFR §438.6(d)(5), the aggregate pass-through payments to physicians or nursing facilities may be no more than the total dollar amount of pass-through payments to physicians or nursing facilities,

¹² In accordance with 42 CFR §438.6(d)(1)(ii), CMS will not approve a retroactive adjustment or amendment, notwithstanding the adjustments to the base amount permitted in 42 CFR §438.6(d)(2), to managed care contract(s) and rate certification(s) to add new pass-through payments or increase existing pass-through payments.

respectively, identified in the managed care contract(s) and rate certification(s) used to meet the requirements of 42 CFR 438.6(d)(1)(i).

(d) the base amount, as defined in 42 CFR §438.6(d)(2), is determined as the sum of (i) and (ii) below:

(i) for inpatient and outpatient hospital services that will be provided to eligible populations through the MCO, PIHP, or PAHP contracts for the rating period that includes pass-through payments and that were provided to the eligible populations under MCO, PIHP, or PAHP contracts two years prior to the rating period, the state must determine reasonable estimates of the aggregate difference between:

(A) the amount Medicare FFS would have paid for those inpatient and outpatient hospital services utilized by the eligible populations under the MCO, PIHP, or PAHP contracts for the 12-month period immediately two years prior to the rating period that will include pass-through payments; and

(B) the amount the MCOs, PIHPs, or PAHPs paid (not including pass-through payments) for those inpatient and outpatient hospital services utilized by the eligible populations under MCO, PIHP, or PAHP contracts for the 12-month period immediately 2 years prior to the rating period that will include pass-through payments.

(ii) for inpatient and outpatient hospital services that will be provided to eligible populations through the MCO, PIHP, or PAHP contracts for the rating period that includes pass-through payments and that were provided to the eligible populations under Medicaid FFS for the 12-month period immediately 2 years prior to the rating period, the state must determine reasonable estimates of the aggregate difference between:

(A) the amount Medicare FFS would have paid for those inpatient and outpatient hospital services utilized by the eligible populations under Medicaid FFS for the 12-month period immediately 2 years prior to the rating period that will include pass-through payments; and

(B) the amount the state paid under Medicaid FFS (not including pass-through payments) for those inpatient and outpatient hospital services utilized by the eligible populations for the 12-month period immediately 2 years prior to the rating period that will include pass-through payments.

(e) in accordance with 42 CFR §438.6(d)(2)(iii), the base amount must be calculated on an annual basis and is recalculated annually.

- (f) the impact of any §438.6(c) directed payments made to hospitals during the 12-month period immediately 2 years prior to the rating period should be included when calculating amounts in Section I, Item 4.E.i.d.i.B of the guide.
 - (g) in accordance with 42 CFR §438.6(d)(2)(iv), states may calculate reasonable estimates of the aggregate differences in paragraph (d) in accordance with the upper payment limit requirements in 42 CFR part 447.
 - (i) if the state chooses to utilize a trend adjustment when calculating reasonable estimates of the aggregate differences in paragraph (d), it must provide a justification of why an adjustment is reasonable and appropriate, and the state should utilize the same data source for the trend adjustments when calculating amounts in Section I, Item 4.E.i.d.i.A, Section I, 4.E.i.d.i.B, Section I, Item 4.E.i.d.ii.A, and Section I, 4.E.i.d.ii.B of the guide.
 - (h) capitation rates may only include pass-through payments to hospitals, physicians and nursing facilities when permitted by 42 CFR §438.6(d); states may not include pass-through payments to providers other than hospitals, physicians, and nursing facilities in the capitation rates.
 - (i) if a state chooses to include a pass-through payment as a per member per month (PMPM) amount, tied to enrollment, the state must monitor the actual pass-through payment amounts paid during the rating period to ensure it does not exceed the amount permitted under 42 CFR 438.6(d) to ensure compliance with the regulation. If the actual enrollment were to vary in a way that increases the pass-through payments beyond the allowable amount, the state must amend the rates to comply with Federal requirements. Additionally, the state must include the maximum dollar amount of pass-through payment amounts permitted under 42 CFR 438.6(d) within its contracts with managed care plans.
- ii. Appropriate Documentation
- (a) the rate certification and supporting documentation must include a description of each existing pass-through payment incorporated into the rates for this rating period. An adequate description includes at least the following for each pass-through payment:
 - (i) a description of the pass-through payment, including the provider type (e.g. hospital, nursing facility, or physician).
 - (ii) the amount of the pass-through payment, both in total and on a per member per month basis (if applicable).
 - (iii) the program(s) that includes the pass-through payment.
 - (iv) the providers receiving the pass-through payment.

- (v) the financing mechanism for the pass-through payment.
 - (vi) identification of any §438.6(c) directed payment arrangement(s) which target the same providers receiving the pass-through payment.
- (b) the rate certification and supporting documentation must include a description of the aggregate pass-through payments incorporated into the rates for this rating period by provider type. An adequate description includes at least the following for the pass-through payments by provider type:
- (i) the amount of pass-through payments by provider type both in total and on a per member per month basis (if applicable).
 - (ii) documentation of historical pass-through payments by provider type that are a prerequisite for authorization to use a transition period (as outlined in 42 CFR §438.6(d)(1)(i)):
 - (A) if the managed care contract(s) and rate certification(s) for the rating period that includes July 5, 2016 were submitted to CMS on or before July 5, 2016, please provide:
 1. the total aggregate amount of pass-through payments per provider type (i.e. hospital, physician and nursing facility) incorporated into capitation rates for the rating period in effect on July 5, 2016.
 2. the date(s) the managed care contract(s) and rate certification(s) were submitted to CMS for review and approval.
 - (B) if the managed care contract(s) and rate certification(s) for the rating period that includes July 5, 2016 had not been submitted to CMS on or before July 5, 2016, please provide:
 1. the total aggregate amount of pass-through payments by provider type incorporated into capitation rates for the rating period before July 5, 2016 that had been most recently submitted for CMS review and approval as of July 5, 2016.
 2. The date(s) the managed care contract(s) and rate certification(s) were submitted to CMS for review and approval.
- (c) in accordance with 42 CFR §438.6(d)(4), the certification must document the following information about the base amount for hospital pass-through payments:
- (i) the data, methodologies, and assumptions used to calculate the base amount, including the data, methodologies and assumptions for any reasonable estimate(s) utilized.

- (i) the description must include a summary of any adjustment made to the base data used to calculate amounts for Section I, Item 4.E.i.d.i.A, Section I, 4.E.i.d.i.B, Section I, Item 4.E.i.d.ii.A, and Section I, 4.E.i.d.ii.B of the guide, including a rationale and fiscal impact of each adjustment.
- (ii) the aggregate amounts calculated for Section I, Item 4.E.i.d.i.A, Section I, 4.E.i.d.i.B, Section I, Item 4.E.i.d.ii.A, and Section I, 4.E.i.d.ii.B of this guide.
- (iii) if the state chooses to utilize trend adjustments when calculating the amounts identified in Section I, Item 4.E.i.d.i.A, Section I, 4.E.i.d.i.B, Section I, Item 4.E.i.d.ii.A, and Section I, 4.E.i.d.ii.B of the guide, the state must ensure clear documentation, including:
 - (i) explanation of the purpose of the trend adjustment (e.g. cost inflation, utilization, etc.) and justification of why an adjustment is reasonable and appropriate.
 - (ii) the trend adjustment applied to amounts, as applicable, in Section I, Item 4.E.i.d.i.A, Section I, 4.E.i.d.i.B, Section I, Item 4.E.i.d.ii.A, and Section I, 4.E.i.d.ii.B of the guide.
 - (iii) a description of the data source, assumptions, and methodology used to determine each adjustment.
 - (iv) the fiscal impact of each trend adjustment.
 - (v) if the state does not utilize a consistent data source for the trend adjustment used in the base amount calculation and demonstrations of upper payment limits requirements for inpatient and outpatient hospital services in accordance with 42 CFR 447, the state must provide a clear rationale of why a different data source is reasonable and appropriate for the trend adjustments used in the base amount calculation.
- (iv) the calculation of the applicable percentage of the base amount available for pass-through payments under the schedule in Section I, Item 4.E.i.c. of the guide.
- (v) the amount of any §438.6(c) directed payment arrangements made to hospitals during the 12-month period immediately 2 years prior to the rating period, and an explanation of how these were included in the calculations of amounts in Section I, Item 4.E.i.d.i.B of the guide.

5. Projected Non-Benefit Costs

A. Rate Development Standards

- i. In accordance with 42 CFR §438.5(e), the development of the non-benefit component of the rate must include reasonable, appropriate, and attainable expenses related to MCO, PIHP or PAHP administration, taxes, licensing and regulatory fees, contribution to reserves, risk margin, and cost of capital. In addition, the non-benefit component must include other operational costs associated with the provision of services under the contract, including those administrative costs for compliance with the mental health parity standards in 42 CFR 438.3, subpart K.
- ii. Non-benefit costs may be developed as per member per month (PMPM) costs or as a percentage of projected benefit costs or capitation rates, and different approaches can be taken for different categories of costs. For non-benefit costs that may be difficult to allocate to specific enrollees or groups of enrollees, or for taxes and fees that are assessed as a percentage of premiums, it may be reasonable to calculate those non-benefit costs as a percentage of benefit costs or capitation rates.
- iii. Variations in the assumptions used to develop the projected non-benefit costs for covered populations must be based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations.
- iv. Section 9010 of the Patient Protection and Affordable Care Act imposes a Health Insurance Providers Fee on each covered entity engaged in the business of providing health insurance for United States health risk. CMS policy regarding how this fee may be considered in Medicaid managed care rate development is outlined in CMS's "Medicaid and CHIP FAQs: Health Insurance Providers Fee for Medicaid Managed Care Plans," dated October 2014.¹³ States have the flexibility to account for the Health Insurance Providers Fee on a prospective or retrospective basis into rate development for either the data year or fee year. Any payment for the fee must be incorporated in the health plan capitation rates.
 - (a) due to the health insurance provider fee moratorium established by the Consolidated Appropriations Act of 2016 and continuing resolution legislation, Pub. Law. 115-120 (H.R. 195), Division D – Suspension of Certain Health-Related Taxes, § 4003, CMS does not expect any health insurance provider fees to be paid for calendar year 2017 and 2019 by managed care plans that are subject to that fee. Therefore, no amounts should be included in Medicaid managed care capitation rates for fees that would have been paid by plans to the IRS for 2017 or 2019 (which would have been assessed off of 2016 and 2018 net premiums, respectively).¹⁴ This fee remains in effect for calendar year 2018 and 2020. The

¹³ <https://www.medicaid.gov/federal-policy-guidance/downloads/faq-10-06-2014.pdf>

¹⁴ More information on this issue can be found at: <https://www.irs.gov/Businesses/Corporations/Affordable-Care-Act-Provision-9010>

Further Consolidated Appropriations Act, 2020, Division N, Subtitle E § 502 repealed the annual fee on health insurance providers for calendar years beginning after December 31, 2020.

B. Appropriate Documentation

- i. The rate certification and supporting documentation must describe the development of the projected non-benefit costs included in the capitation rates in enough detail so CMS or an actuary applying generally accepted actuarial principles and practices can identify each type of non-benefit expense that is included in the rate and evaluate the reasonableness of the cost assumptions underlying each expense in accordance with 42 CFR §438.7(b)(3). To meet this standard, the documentation must include:
 - (a) a description of the data, assumptions, and methodologies used to develop the projected non-benefit costs, and in particular, all significant and material items in developing the projected non-benefit costs.
 - (b) any material changes to the data, assumptions, and methodologies used to develop projected non-benefit costs since the last rate certification.
 - (c) any other material adjustments must be described in accordance with 42 CFR §438.7(b)(4), including:
 - (i) a description of the data, assumptions, and methodologies used to determine each adjustment.
 - (ii) where in the rating setting process each adjustment was applied.
 - (iii) the cost impact of each material adjustment.
- ii. States and actuaries should estimate the projected non-benefit costs for each of the following categories of costs:
 - (a) administrative costs.
 - (b) taxes, licensing and regulatory fees, and other assessments and fees.
 - (c) contribution to reserves, risk margin, and cost of capital.
 - (d) other operational costs associated with the provision of services identified in 438.3(c)(1)(ii) to the populations covered under the contract.
- iii. Actuaries should disclose historical non-benefit cost data in the certification to the extent this information was provided by the plans, and explain how the historical non-benefit cost data was considered in the non-benefit cost assumptions used in rate development.
- iv. Regarding the Health Insurance Providers Fee, the rate certification and supporting documentation must:

- (a) specifically address how this fee is incorporated into capitation rates if the managed care plan is required to pay the fee for 2020.
- (b) if the fee is incorporated into the rates in the initial rate certification, an explanation of whether the amount included in the rates is based on the data year or fee year during the rating period of the rate certification.
- (c) a description of how the amount of the fee was determined, and whether or not any adjustments would be made to the rates once the actual amount of the fee is known.
- (d) if the fee is not incorporated into the rates in the rate certification because the rates will be adjusted to account for the fee subsequently, an explicit statement that the fee is not included, and a description of when and how the rates will ultimately be adjusted to account for the fee.
- (e) if the capitation rates include benefits as described in 26 CFR §57.2(h)(2)(ix) (e.g., long-term care, nursing home care, home health care, or community-based care), CMS recommends that the per member per month cost associated with those benefits be explicitly reported as a separate amount in the rate certification in order to more accurately account for the appropriate revenue on which the plans will be assessed.
- (f) for managed care plans that were required to pay the fee in 2014, 2015, 2016, and/or 2018, a description as to whether or not the fee has been included in the capitation rates for those years (either prospectively in the rates or through amendments to the initially certified rates).

6. Risk Adjustment and Acuity Adjustments

A. Rate Development Standards

- i. Risk adjustment is a methodology to account for the health status of enrollees via relative risk factors when predicting or explaining costs of services covered under the contract for defined populations or for evaluating retrospectively the experience of MCOs, PIHPs, or PAHPs contracted with the state.
- ii. As required by 42 CFR §438.5(g), if risk adjustment is applied prospectively or retrospectively, states and their actuaries must select a risk adjustment methodology that uses generally accepted models and must apply it in a budget neutral manner, consistent with generally accepted actuarial principles and practices, across all MCOs, PIHPs or PAHPs in the program to calculate adjustments to the payments as necessary.
- iii. An adjustment applied to the total payments across all managed care plans to account for significant uncertainty about the health status or risk of a population is considered

an acuity adjustment, which is a permissible adjustment under 42 CFR §438.5(f) (81 FR 27595).

- (a) acuity adjustments may be used prospectively or retrospectively.
- (b) while retrospective acuity adjustments may be permissible, they are intended solely as a mechanism to account for differences between assumed and actual health status when there is significant uncertainty about the health status or risk of a population, such as: (1) new populations coming into the Medicaid program; or (2) a Medicaid population that is moving from FFS to managed care when enrollment is voluntary and there may be concerns about adverse selection. In the latter case, there may be significant uncertainty about the health status of which individuals would remain in FFS versus move to managed care; although this uncertainty is expected to decrease as the program matures.
- (c) CMS may also consider acuity adjustments as a risk mitigation strategy when there is unusual and significant uncertainty about the health status of the population (e.g., covering a new population in Medicaid).

B. Appropriate Documentation

- i. In accordance with 42 CFR §438.7(b)(5)(i), the rate certification must describe all prospective risk adjustment methodologies, including:
 - (a) the data, and any adjustments to that data, to be used to calculate the adjustment.
 - (b) the model, and any adjustments to that model, to be used to calculate the adjustment.
 - (c) the method for calculating the relative risk factors and the reasonableness and appropriateness of the method in measuring the risk factors of the respective populations.
 - (d) the magnitude of the adjustment on the capitation rate per MCO, PIHP, or PAHP.
 - (e) an assessment of the predictive value of the methodology compared to prior rating periods.
 - (f) any concerns the actuary has with the risk adjustment process.
- ii. In accordance with 42 CFR §438.7(b)(5)(ii), the rate certification must describe all retrospective risk adjustment methodologies, including:
 - (a) the party calculating the risk adjustment.
 - (b) the data, and any adjustments to that data, to be used to calculate the adjustment.
 - (c) the model, and any adjustments to that model, to be used to calculate the adjustment.

- (d) the timing and frequency of the application of the risk adjustment.
- (e) any concerns the actuary has with the risk adjustment process.
- iii. The rate certification and supporting documentation must also specifically include:
 - (a) any changes that are made to risk adjustment models since the last rating period.
 - (b) documentation that the risk adjustment model is budget neutral in accordance with 42 CFR §438.5(g).
- iv. If an acuity adjustment is being used, the rate certification must include a description of the acuity adjustment and its basis that is adequate to evaluate its reasonableness and whether it is consistent with generally accepted actuarial principles and practices. Such a description includes at least:
 - (a) the reason that there is significant uncertainty about the health status of the population and the need for an acuity adjustment.
 - (b) the acuity adjustment model(s) being used to calculate acuity adjustment scores.
 - (c) the specific data, including the source(s) of the data, being used by the acuity adjustment model(s).
 - (d) the relationship and potential interactions between the acuity adjustment.
 - (e) how frequently the acuity adjustment scores are calculated.
 - (f) a description of how the acuity adjustment scores are being used to adjust the capitation rates.
 - (g) documentation that the acuity adjustment mechanism has been developed in accordance with generally accepted actuarial principles and practices.

Section II. Medicaid Managed Care Rates with Long-Term Services and Supports

This section of the guidance is directed to all states setting Medicaid managed care rates that are subject to the actuarial soundness requirements in 42 CFR §438.4 and include long-term services and supports (LTSS) as defined at 42 CFR §438.2(a). In determining whether or not rates have been developed in accordance with generally accepted actuarial practices and principles, CMS will apply the specific considerations below.

1. Managed Long-Term Services and Supports

- A. For managed long-term services and supports (MLTSS) programs, or for programs that include MLTSS as part of the covered benefits, the guidance above in Section I of the

guide regarding the required standards for rate development and CMS’s expectations for appropriate documentation required in the rate certification is also applicable for rates for provision of MLTSS.

B. Rate Development Standards

- i. States may take different approaches for rate setting for MLTSS. The two most common approaches are to structure the rate cells:
 - (a) by health care status and the level of need of the beneficiaries (“blended”); or
 - (b) by the long-term care setting that the beneficiary uses (“non-blended”).

C. Appropriate Documentation

- i. The rate certification and supporting documentation for MLTSS programs, or for programs that include MLTSS as part of the covered benefits must also specifically address the following considerations:
 - (a) the structure of the capitation rates and rate cells or rating categories (e.g. blended, non-blended, etc.).
 - (b) the structure of the rates and the rate cells, and the data, assumptions, and methodology used to develop the rates in light of the overall rate setting approach.
 - (c) any other payment structures, incentives, or disincentives used to pay the MCOs, PIHPs or PAHPs (for example, states may provide additional payments to plans that transition beneficiaries from institutional long-term care settings into other settings, or may pay adjusted rates during time periods of setting transitions).
 - (d) the expected effect that managing LTSS has on the utilization and unit costs of services.
 - (e) any effect that the management of this care is expected to have within each care setting and any effect in managing the level of care that the beneficiary receives (e.g., in-home care, community long-term care, nursing facility care).
- ii. The projected non-benefit costs, such as administrative costs and care coordination costs, may differ for populations receiving MLTSS from other managed care programs, and the rate certification should describe how the projected non-benefit costs were developed for populations receiving these services.
- iii. The rate certification should provide information on historical experience, analysis, and other sources (e.g., studies or research) used to develop the assumptions used for rate setting.

Section III. New Adult Group Capitation Rates

This section of the guidance is focused on rate setting for the new adult group under section 1902(a)(10)(A)(i)(VIII) (“new adult group”) of the Social Security Act. For states that have previously covered the new adult group, this guide describes the information expected from states related to how the capitation rates or the rate development process has changed since the most recent rate certification. Because this is a newly eligible group, CMS expects that rate development may require additional review in this area to ensure that rates are developed in accordance with generally accepted actuarial practices and principles. To support such review, CMS expects states to provide additional documentation as described below.

1. Data

- A. In addition to the expectations for all Medicaid managed care rate certifications, as supported by assurances from the state, described in Section I of the guide, the rate certification must describe the data used to develop new adult group rates, particularly where different or additional data was used.
- B. For states that have covered the new adult group in Medicaid managed care plans in previous rating periods (i.e. starting in 2014, 2015, 2016, 2017, 2018, 2019 and/or January through June 2020), CMS expects the rate certification, as supported by assurances from the state, to describe:
 - i. Any new data that is available for use in this rate setting.
 - ii. How the state and the actuary followed through on any plans to monitor costs and experience for newly eligible adults.
 - iii. How actual experience and costs in previous rating periods have differed from assumptions and expectations in previous rate certifications.
 - iv. How differences between projected and actual experience in previous rating periods have been used to adjust these rates.

2. Projected Benefit Costs

- A. In addition to the guidance for all Medicaid managed care rate certifications described in Section I of the guide, states should include in the rate certification submission and supporting documentation a description of the following issues related to the projected benefit costs for the new adult group:
 - i. For states that covered the new adult group in previous rating periods:
 - (a) any data and experience specific to the new adult group covered in previous rating periods that was used to develop projected benefits costs for capitation rates.
 - (b) any changes in data sources, assumptions, or methodologies used to develop projected benefits costs for capitation rates since the last rate certification.

- (c) how assumptions changed from rate certification(s) for previous rating periods on the following issues:
 - (i) acuity or health status adjustments (in most cases comparing the new adult group enrollees to other Medicaid adult enrollees).
 - (ii) adjustments for pent-up demand.
 - (iii) adjustments for adverse selection.
 - (iv) adjustments for the demographics of the new adult group.
 - (v) differences in provider reimbursement rates or provider networks, including any differences between provider reimbursement rates or provider networks for new adult group rates and other Medicaid population rates.
 - 1. variations in the assumptions used to develop the projected benefit costs for covered populations must be based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations.
 - (vi) other material changes or adjustments to the new adult group projected benefit costs.
 - (vii) any changes to the benefit plan offered to the new adult group.
- ii. For states that did not cover the new adult group in previous rating periods:
 - (a) descriptions of any differences of the benefit plan offered to the new adult group population and other covered populations (i.e., the non-new adult group population).
- iii. For any state that is covering the new adult group, regardless if they have been covered in previous rating periods, the following key assumptions related to the new adult group must be identified and described in the rate certification and supporting documentation:
 - (a) Acuity or health status adjustments (in most cases comparing new adult group enrollees to other Medicaid adult enrollees).
 - (b) Adjustments for pent-up demand.
 - (c) Adjustments for adverse selection.
 - (d) Adjustments for the demographics of the new adult group.
 - (e) Differences in provider reimbursement rates or provider networks, including any differences between provider reimbursement rates or provider networks for the new adult group rates and other Medicaid population rates.

- (f) Other material adjustments to the new adult group projected benefit costs.
- B. The rate certification and supporting documentation must describe The rate certification and supporting documentation must describe any other material changes or adjustments to projected benefit costs.

3. Projected Non-Benefit Costs

- A. In addition to the guidance all Medicaid managed care rate certifications described in Section I of the guide, states must include in the rate certification submission and supporting documentation a description of the following issues related to the projected non-benefit costs for the new adult group:
 - i. For states that covered the new adult group in Medicaid managed care plans in previous rating periods, any changes in data sources, assumptions, or methodologies used to develop projected non-benefit costs since the last rate certification.
 - ii. How assumptions changed from the rate certification(s) for previous rating periods on the following issues:
 - (a) administrative costs.
 - (b) care coordination and care management.
 - (c) provision for operating or profit margin.
 - (d) taxes, fees, and assessments.
 - (e) other material non-benefit costs.
- B. The rate certification and supporting documentation must include information on key assumptions related to the new adult group and any differences between the assumptions for this population and the assumptions used to develop projected non-benefit costs for other Medicaid populations for the following issues:
 - i. Administrative costs.
 - ii. Care coordination and care management.
 - iii. Provision for operating or profit margin.
 - iv. Taxes, fees, and assessments.
 - v. Other material non-benefit costs.

4. Final Certified Rates

- A. In addition to the expectations for all Medicaid managed care rate certifications described in Section I of the guide, CMS requests under 42 CFR §438.7(d)¹⁵ that states that covered the new adult group in Medicaid managed care plans in previous rating periods provide:
 - i. A comparison to the final certified rates or rate ranges in the previous rate certification.
 - ii. A description of any other material changes to the capitation rates or the rate development process not otherwise addressed in the other sections of this guidance.

5. Risk Mitigation Strategies

- A. CMS requests under 42 CFR §438.7(d) that states describe the risk mitigation strategy specific to the new adult group rates.
- B. For states that covered the new adult group in Medicaid managed care plans in previous rating periods, CMS requests the following information:
 - i. Any changes in the risk mitigation strategy from those used during previous rating periods.
 - ii. The rationale for making the change in the risk mitigation strategy or removing the risk mitigation used during previous rating periods. For states that utilize a risk mitigation strategy specific to the new adult group for the initial rating period that included this population, CMS believes this risk mitigation strategy should continue to be utilized until the following three criteria are met:
 - (a) the state uses data only from the new adult group's experience to develop capitation rates;
 - (b) the state has settled or reconciled previous risk mitigation terms in their contract (e.g., MLR, risk corridor) to assess the appropriateness of their previous rate development; and
 - (c) the state can demonstrate that capitation rates are stable, or that rates have been adjusted consistent with differences in early experience.
 - iii. Any relevant experience, results, or preliminary information available related to the risk mitigation strategy used during previous rating periods.

¹⁵ The regulation provides: (d) *Provision of additional information*. The State must, upon CMS' request, provide additional information, whether part of the rate certification or additional supplemental materials, if CMS determines that information is pertinent to the approval of the certification under this part. The State must identify whether or not the information provided in addition to the rate certification is proffered by the State, the actuary, or another party.

Appendix A: CMS MEDICAID MANAGED CARE RATE DEVELOPMENT SUMMARY FOR ACCELERATED RATE REVIEWS

Introduction

As part of the Centers for Medicare & Medicaid Services' (CMS) review of Medicaid managed care rates, CMS is implementing an accelerated rate review process. This appendix summarizes the accelerated rate review process, criteria for a state to use the accelerated rate review process, and the documentation required from a state that participates in the accelerated rate review process. In particular, states that elect to use the accelerated rate review process must submit a Rate Development Summary that identifies several key elements. The elements of the Rate Development Summary are described further below. The accelerated rate review process will focus on reviewing those key elements.

To qualify for review under the accelerated review process, a rate certification must meet the criteria outlined below. The accelerated review will be of all rates covered by a rate certification that qualifies for accelerated review. Each state ultimately elects whether to request to participate in the accelerated rate review process. A state may have one, more, or all rate certifications for its Medicaid managed care program(s) reviewed through the accelerated process, depending on the state's election and whether the particular rate certification qualifies. New initial rate certifications and rate amendments to those certifications may qualify for the accelerated review process.

A full review of all rate certifications will be required every 3 years, or earlier if CMS determines a full review must be performed. Amendments to initial rate certifications that were reviewed under the accelerated rate review process will also be reviewed under the accelerated rate review process, unless the rate amendment does not meet the criteria (below) or CMS has identified material issues in the initial rate certification for the rate amendment.

Under the accelerated rate review process, for certifications that meet the criteria for participation in the accelerated rate review, states must submit the following:

- (1) the Rate Development Summary,
- (2) the full rate certification and related supporting documents, and
- (3) the executed managed care plan contracts for the certified rates.

All materials described in this Rate Development Guide must be submitted plus the Rate Development Summary. The accelerated review will focus on the elements in the Rate Development Summary, and CMS's review will extend to the full rate certification when more support, detail, or clarification is needed for the review. In the event there are still questions after that initial review, CMS will contact that state and the actuary with questions (which may be in writing and/or through a call).

Criteria for a Rate Certification to Qualify for Accelerated Rate Review

There are several criteria that must be met for a rate certification to qualify for accelerated rate review of the rates for the rating period beginning between July 1, 2020 – June 30, 2021. The criteria are:

1. The state submits a timely request for the accelerated review process and timely submits the rate certification and required materials for review. Further information is in the “Required Submission Process and Materials” section below.
2. The review of the prior rating period’s capitation rate certification must be completed.
3. There has been a full review of the capitation rate certification for at least one of the two prior rating periods.
4. The managed care program covered by the rate certification has been in operation for at least 24 months.
5. The same actuary or actuarial firm is developing the rates since the previous full review.
6. No material issues have been identified (by any party) in rate setting for the prior rating period. CMS retains discretion to determine whether or not there were material issues that were identified in rate setting during the prior rating period, and therefore states should give CMS prior notice if their intention is to participate in the accelerated rate review. Material issues are generally discussed through extensive questioning or conference calls.
7. There are no material policy, programmatic, or legal issues related to the state’s managed care program, in the prior rating period or for the rating period under review.

In addition, CMS retains the discretion to determine whether to conduct an accelerated rate review or a full rate review. The following criteria are a non-exhaustive list of considerations CMS will use in determining whether to conduct a full review instead of an accelerated review:

1. Identification of any material issues related to rate setting during the accelerated review.
2. Identification of significant discrepancies or errors in the Rate Development Summary or rate certification materials.
3. Identification of significant changes to the rate development methodologies and/or the program.

CMS may choose to request additional information or corrective action in lieu of a full review of a rate certification.

Required Submission Process and Materials

States must adhere to the following procedural requirements to participate in the accelerated rate review:

1. Request to participate in the accelerated review 120 days in advance of the start of the rating period by submitting the request to MMCratesetting@cms.hhs.gov and the DMCO designated mailbox. One request per certification should be submitted. Depending on the release of this Rate Guide this timeline may not be possible for rating periods beginning July 1, 2020. In such situations, the state should submit the request as soon as possible.

States may send questions regarding eligibility to participate in the accelerated rate review process to MMCratesetting@cms.hhs.gov.

CMS will notify the state within 2 weeks after their request has been submitted whether or not the certification qualifies for the accelerated review.

2. Submit the following documents to MMCratesetting@cms.hhs.gov and the DMCO designated mailbox at least 90 days in advance of the rating period:
 - (1) The Rate Development Summary, including all of the elements outlined in the next section;
 - (2) The full rate certification and all supporting documentation; and
 - (3) Executed contract(s) with signature pages for every managed care plan operating in the Medicaid, combined Medicaid/CHIP or separate CHIP managed care program(s) that will be subject to the accelerated rate review.
 - i. Because many states face challenges in providing rate certifications and executed contracts at the same time, CMS will accept finalized rate certifications in advance of the state submitting all other finalized components of the standardized contract submission.
 - ii. Note: Some contract submissions also require additional documentation, such as the annual summary of managed care plans' medical loss ratio reports, readiness review results and/or parity analysis. Please see the Addendum included in [CMCS Informational Bulletin, dated November 8, 2019](#), for additional guidance.

Required Elements for Rate Development Summary

1. Rates

The Rate Development Summary must identify all certified rates for the rating period and must indicate whether the certified rates have been risk adjusted or the actuary has certified the risk adjustment methodology and the certified rates will be risk adjusted in the future.

The rates can be provided in two ways. First, a table can be provided, such as the table below. This is CMS's preference.

Rate Cell (Region, Plan, etc.)	Rate (PMPM)
A	\$X
B	\$X
C	\$X

Alternatively, the Rate Development Summary can specify exactly where in the rate certification (and any additional materials) that the rates are provided at this level of detail.

2. Changes in rates from last rating period or initial certification

The Rate Development Summary must compare the rates for this rating period to either (1) the rates from the previous rating period in the case of a new certification or (2) the rates from the initial certification or most recent rate amendment in the case of a rate amendment. This will be used to identify rate changes that are unusually large or that appear to be inconsistent with the changes described in the certification.

The information about rate changes can be provided in two ways. First, a table can be provided in the template. This is CMS's preference.

Rate Cell (Region, Plan, etc.)	Rate	Previous Rate	Change
A	\$X	\$Y	Z%
B	\$X	\$Y	Z%
C	\$X	\$Y	Z%
Average	\$X	\$Y	Z%

Average rate changes would also be helpful, and could be provided overall for the rate certification or as appropriate subtotals (aggregating related rate cells together, aggregating all rate cells by plan, etc.). The table can also split the rate change into components if available (for example: projected-to-historical cost differences, trend, programmatic changes, etc.).

Alternatively, the Rate Development Summary can specify exactly where in the rate certification (and any additional materials) that the rate changes are provided at this level of detail.

3. Base Data

The Rate Development Summary must include a description of the base data used, including:

- (1) the sources of data used for the base data (encounter data, fee-for-service data, or other sources);
- (2) an assurance that the base data is consistent with the requirements in the regulation, or a description of why the base data is not consistent with the regulation including the state's rationale of why an exemption is necessary and a description of the actions the state intends to take to come into compliance with the base data requirements in accordance with 42 CFR 438.5(c)(3);
- (3) a description of any data quality issues or concerns identified by the actuary;
- (4) a description of any material adjustments made to the base data; and

- (5) references to where the data is described in more detail in the certification and any additional documents. In addition, the Rate Development Summary can include references to the summarized base data in the certification or additional documents.

This will be used to verify that the data used is consistent with CMS regulation and actuarial standards and to assess any significant issues with or adjustments made to the data for developing rates.

4. Methodology

The Rate Development Summary must include a high-level description of the methodologies used to develop the rates. This section must include a description of any material methodology changes since the last certification and references to descriptions of the methodologies in the rate certification.

5. Trend

The Rate Development Summary must include a summary of the projected benefit cost trends used to develop the rates, including:

- (1) the total average projected benefit cost trend assumption;
- (2) the projected benefit cost trends by category or type of service;
- (3) the projected benefit cost trends by rate cell (or similar level of detail, such as eligibility category);
- (4) the projected benefit cost trends separated into price or unit cost trends, and utilization trends;
- (5) any adjustments applied to develop the projected benefit cost trends;
- (6) comparisons to the previous year's trends; and
- (7) references to where the trends and their development are described in more detail in the certification and any additional documents.

This will be used to verify that the trends are reasonable and consistent with the changes being made to the rates (either in the initial certification or in the rate amendment) and to identify trends that are unusual (for example, larger than expected or negative), or that appear to be inconsistent with the changes described in the certification or rate amendment.

The trends can be provided in several ways. First, the trends can be provided in the tables in the template. We believe that tables showing the trends by service and the average trend by rate cell would be the most useful:

Category of Service	Unit Cost Trend	Utilization Trend	Adjustments to Trend	Overall Trend
A	X%	Y%	Z%	A%
B	X%	Y%	Z%	A%
C	X%	Y%	Z%	A%

Rate Cell (Region, Plan, etc.)	Trend
A	A%
B	A%
C	A%
Total Average	A%

Alternatively, the Rate Development Summary can specify exactly where in the rate certification (and any additional materials) the trends are provided at this level of detail.

6. Non-benefit costs

The Rate Development Summary must summarize non-benefit costs by type or by category (for example, administrative costs, care management (non-benefit), taxes and fees, and profit margin) and identify where the non-benefit costs are described in the rate certification and any additional documents, as well as any comparisons to the previous year's non-benefit costs.

This will be used to verify that the non-benefit costs are reasonable and consistent with the changes being made to the rates (either in the initial certification or in the rate amendment) and to identify costs that are unusual (for example, significant larger or smaller than typical), or that appear to be inconsistent with the changes described in the certification or rate amendment.

The non-benefit costs can be provided in several ways. First, non-benefit costs can be shown by rate cell (or similar level of detail) or an average across all rate cells if costs are similar:

Type of Non-Benefit Cost	Amount
A	X% or \$Y PMPM
B	X% or \$Y PMPM
C	X% or \$Y PMPM
Total	Z% or \$A PMPM

Alternatively, the Rate Development Summary can specify exactly where in the rate certification (and any additional materials) that the non-benefit costs are provided at this level of detail.

7. Program changes

The Rate Development Summary must describe any programmatic changes and the impacts that they are expected to have on the rates. Programmatic changes that must be documented in this Rate Development Summary include: new or changing benefits; changes to provider reimbursement; new or changing populations covered by managed care; new programs or initiatives that would affect managed care; new or changing participating plans; and any other changes to the managed care program that would have a material impact on the rates.

This section must include a description of those changes and the impacts on the rates, and must have references to where these are described in more detail in the certification. This will be used to verify that the program changes are consistent with the changes being made to the rates and to identify large or unusual impacts to the rates.

8. Financial performance

The Rate Development Summary must include recent financial performance of the managed care program and the plans in the program, which could include medical loss ratio (MLR) and/or profit margin by plan. The state must provide some measure of financial performance (MLR or profit margin, preferably by plan, by program, by year) and a comparison to the estimated or assumed measure when developing the rates. The Rate Development Summary must include up to 3 years of experience (or, if the rate certification is for a program with less than 3 years experience, all available years) and a brief definition of the measure chosen.

This will be used as a basis for reviewing past results, including the accuracy of previous rate setting and the stability of program costs and rates. We will review any unexpected results or changes to assess if the proposed rates are consistent with expectations given recent financial performance (for example, if costs have generally been higher than expected, we would expect larger rate increases holding all other factors constant).

This information could be provided in one of two ways. First, the information could be provided in a table such as the one below for each year. This is CMS’s preference.

Plan	Estimated MLR/Profit Margin	Actual MLR/Profit Margin
A	X%	Y%
B	X%	Y%
C	X%	Y%
Average	X%	Y%

Alternatively, the Rate Development Summary can specify exactly where in the rate certification (and any additional materials) that the financial performance results and comparisons are provided.

9. Addressing previous issues

The Rate Development Summary must include a section for the state and its actuary to address any significant issues identified in previous years (if applicable). CMS previously communicated issues to states through approval letters (prior to October 2017), and have also communicated significant issues through calls, emails, or inquired about significant issues during rate certification reviews. This section must include a description of how any issues were considered in setting the rates in the certification or rate amendment, as well as references to where this is described in more detail in the certification.

10. Other rate and policy items

The Rate Development Summary must identify any of the following items that are applicable to the capitation rates and/or the managed care program for the rating period. For each item, this section must include a description of how the rate or policy item was considered in setting the rates in the certification or rate amendment, as well as references to where each item is described in more detail in the certification.

- Institution of mental disease (IMD) services;
- Directed payments (42 CFR 438.6(c));
- Pass-through payments;
- Additional payments added to the rates that currently do not qualify as directed payments or pass-through payments;
- Confirm that any proposed differences among capitation rates according to covered populations are based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations;
- Withhold arrangements;
- Incentive arrangements;
- Risk adjustment;
- Acuity adjustment;
- Reinsurance;
- Minimum medical loss ratio (MLR) requirements;
- Risk corridors;
- Other risk sharing strategies; and
- Other notable policy, Medicaid authority, or programmatic changes.