DEPARTMENT OF HEALTH AND HUMAN SERVICES
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CMCS Informational Bulletin

DATE: July 01, 2016

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SUBJECT: Addendum to 2016 Medicaid Managed Care Rate Development Guide

In September 2015, the Centers for Medicare & Medicaid Services published the 2016 Medicaid Managed Care Rate Development Guide for use in setting capitation rates for rating periods starting in calendar year 2016. This guide can be found at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/2016-medicaid-rate-guide.pdf

Due to the publication of the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule (CMS-2390-F, 81 FR 27498) on May 6, 2016 ("final rule"), CMS is releasing a revision to the 2016 Medicaid Managed Care Rate Development Guide outlined in this informational bulletin to detail the provisions of the final rule that take effect July 5, 2016. The revised 2016 Medicaid Managed Care Rate Development Guide is in effect as of publication of this bulletin.

This informational bulletin discusses:

- The provisions of the final rule that take effect 60 days after publication; and
- Inclusion of new managed care requirements within states' 2016 rate development

Provisions of the final rule that take effect July 5, 2016

The provisions of the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule (CMS-2390-F, 81 FR 27498), published on May 6, 2016, that take effect on July 5, 2016 related to the managed care rate development process are listed in Attachment A of this Informational Bulletin.

Inclusion of new managed care requirements within states' 2016 rate development

States must comply with all provisions of the final rule that take effect on July 5, 2016, including the rate development requirements listed in Attachment A.[1] States should work with their actuaries to assure that rate development for rating periods beginning in 2016 comply with these applicable provisions effective July 5, 2016. CMS will not require additional documentation as part of state's rate submission(s) to CMS; however, CMS may ask clarifying questions as part of our review process as deemed necessary to assure compliance with federal requirements.

[1] An exhaustive list of all provisions of the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule (CMS-2390-F, 81 FR 27498) that take effect July 5, 2016 is available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/implementation-dates.pdf. The provisions that take effect on July 5, 2016, related to the definitions and requirements for actuarially sound capitation rates, are substantially similar to existing requirements for actuarially sound capitation rates in 42 CFR 438.6 of the 2002 rule.

CMS acknowledges that some States already have approved capitation rates for 2016 and that other States have completed their rate development process prior to the publication of the final rule. In light of the mid-year effective and compliance dates of the final rule and these specific provisions, CMS intends to use its enforcement discretion to provide States with a reasonable opportunity to come into compliance with these requirements. CMS does not intend to review and assess already approved rates for compliance with the new final rule rate setting requirements that become effective on July 5, 2016. States with already approved 2016 capitation rates will be expected to be in full compliance by their next rating period.

Similarly, for States that have already developed their Medicaid managed care capitation rates for rating periods starting before October 1, 2016, CMS does not intend to require States to redevelop their capitation rates solely to comply with the new final rule rate setting requirements which become effective on July 5, 2016. For States that otherwise comply with the 2016 Medicaid Managed Care Rate Development Guide, but are not fully compliant with the new regulations, CMS intends to place States on a corrective action plan that requires States to be in full compliance by their next rating period.

Finally, States with rating periods beginning on or after October 1, 2016, that have not yet had contracts and rates for that period reviewed and approved by CMS, will be expected to fully comply with the new final rule rate setting requirements that become effective on July 5, 2016.

Technical Assistance

For questions related to the 2016 Medicaid Managed Care Rate Development Guide or this addendum, please contact MMCratesetting@cms.hhs.gov. For questions related to the final rule, please contact ManagedCareRule@cms.hhs.gov.

Attachment A

Citation	Description
§438.2	Definitions (generally applicable to 42 CFR part 438)
§438.3(c)	Payment for services: capitation rates must be reflected in the contract submitted for CMS review and approval; based on covered services and services required under Part 438, subpart K; and for Medicaid-eligible enrollees.
§438.3(e)	Services that may be covered by an MCO, PIHP, or PAHP
§438.4(a)	Actuarial soundness; Actuarially sound capitation rates defined
§438.4(b)(1)	Actuarial soundness; CMS review and approval of actuarially sound capitation rates – developed in accordance with §438.5 and differences among capitation rates must be based on valid rating factors
§438.4(b)(2)	Actuarial soundness; CMS review and approval of actuarially sound capitation rates – appropriate for populations covered and services furnished under the contract
§438.4(b)(5)	Actuarial soundness; CMS review and approval of actuarially sound capitation rates – payments from any rate cell must not cross-subsidize or be cross-subsidized by payments from any other rate cell
§438.4(b)(6)	Actuarial soundness; CMS review and approval of actuarially sound capitation rates – certified by actuary as meeting requirements of this part
§438.5(a)	Rate development standards - definitions
§438.5(g)	Rate development standards – risk adjustment is developed in a budget neutral manner and consistent with generally accepted actuarial principles and practices
§438.6(a)	Special contract provisions related to payment - definitions
§438.6(b)(1)	Special contract provisions related to payment - Basic requirements, risk sharing mechanisms must be described in the contract, developed consistent with §§438.4 and 438.5), and consistent with generally accepted actuarial principles and practices
§438.6(b)(2)	Special contract provisions related to payment - Incentive arrangements, limits and conditions
§438.6(e)	Payments to MCOs and PIHPs for enrollees that are a patient in an institution for mental disease
§438.7(a)	CMS review and approval of the rate certification
§438.7(d)	Provision of additional information