DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

Draft 2016 Medicaid Managed Care Rate Development Guide

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Introduction

The Centers for Medicare and Medicaid Services (CMS) is releasing the 2016 Medicaid Managed Care Rate Development Guide for use in setting rates for rating periods starting in calendar year 2016 for any managed care program subject to the actuarial soundness requirements in 42 CFR §438.6. This rate development guide builds upon previous Consultation Guides and the experience of states and CMS in completing rate certifications and reviews.

As with prior years, the primary goal of this guide is to describe information that CMS expects states and their actuaries to provide when developing actuarial rate certifications. One of the lessons learned from implementation of previous rate development guidance was that our guidance needed to be more detailed to get more consistent and complete documentation included in the rate certifications. We expect that the information outlined in this guide will be included within the actuarial certification in enough detail so that CMS can determine if the data, assumptions, and methodologies are consistent with generally accepted actuarial practices and principles and if the capitation rates are appropriate for the populations and services to be covered.

The regulation requires that the capitation rates be actuarially sound, meaning that they are certified by an actuary that meets the standards set forth in 42 CFR §438.6, appropriate for the covered population and services, and have been developed in accordance with generally accepted actuarial practices and principles. In applying the regulation standards, CMS will 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 generally accepted actuarial practices and principles.

CMS has developed 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 in light of the more limited experience covering this population.

CMS anticipates that most of the information discussed in this guide is already part of ongoing actuarial work and program management in states. We provide 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. At this time, CMS does not prescribe a specific format for supplying this information although it is expected that each of the relevant sections below are discussed in sufficient detail in the actuarial rate 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 §438.6. CMS believes the documentation standards outlined below are consistent with requirements in 42 CFR §438.6 and relevant Actuarial Standards of Practice. 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 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, which will become effective on August 1, 2015, is especially relevant because it focuses on the development of Medicaid managed care rates and the requirements under 42 CFR §438.6.

1. General Information

A. Rate certifications should be done on an annual basis, except:

   i. 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);

   ii. 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; or

   iii. the state has discussed the need for an alternative rating period length with CMS in advance of developing the rates.

B. States and their actuaries must document all the elements described within their rate certifications to provide enough detail that CMS is able to determine whether the regulation standards are met. In evaluating the certification, CMS will look to the reasonableness of the information contained in the certification for the purposes of rate development. States and their actuaries should ensure that the following elements are properly documented:

   i. Data used, including citations to studies, research papers, other states' analyses, or similar secondary data sources;

ii. assumptions made, including any basis or justification for the assumption; and

iii. methods for analyzing data and developing assumptions and adjustments.

C. The rate certification shall include an index that documents the page number for the items described within this guidance. In cases where not all sections of this guidance are relevant for a particular the rate certification (i.e., an amended certification that adds a new benefit for part of the year), all of the sections in this guidance shall still be provided with the sections of the guidance that are not applicable to the specific certification so noted.

D. To be acceptable, the rate certification submission, as supported by the assurances from the state, must include the following items and information:

i. A letter from the certifying actuary, who meets the requirements in 42 CFR §438.6, that certifies that the final capitation rates or rate ranges meet the standards in 42 CFR §438.6;

ii. the final and certified capitation rates or the final and certified rate ranges for all rate cells and regions;

iii. if rate ranges are certified, assurances that the capitation rate for each rate cell is within the certified rate range; and

iv. brief descriptions of the following information (to show that the actuary developing the rates has an appropriate understanding of the program for which he or she is setting rates):

(a) A summary of the specific state Medicaid managed care programs covered by the certification. This would include, but not be limited to, the types and numbers of managed care plans included in the rate development, the areas of the state covered by the managed care rates and approximate length of time the managed care program has been in operation.

(b) The rating periods covered by the certification.

(c) The Medicaid populations covered through the managed care programs for which the certification applies.

(d) 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).

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

2. Data

A. The rate certification, as supported by the assurances from the State, must thoroughly describe the data used to develop the capitation rates including:

i. A description of the data, including:

(a) 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.

(b) The age or time periods of all data used.

(c) The sources of all data used (e.g., State Medicaid Agency; other state agencies; health plans; or other third parties).

(d) 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.

ii. Information related to the availability and the quality of the data used for rate development, including:

(a) 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:

(i) Completeness of the data;

(ii) accuracy of the data; and

(iii)consistency of the data across data sources.

(b) A summary of the actuary's assessment of the data.

(c) Any other concerns that the actuary has over the availability or quality of the data.

iii. If fee-for-service claims or managed care encounter data are not used (or are not available), an explanation of why that data was not used (or was not available) and why the data used in rate development is appropriate for setting capitation rates for the populations and services to be covered.

iv. If the managed care program is considered mature and has been in operation for more than three years, but managed care encounter data was not used in the rate

development, 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.

v. 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.

B. 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:

i. The credibility of the data;

ii. completion factors;

iii. errors found in the data;

iv. 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); and

v. exclusions of certain payments or services from the data.

3. Projected Benefit Costs and Trends

A. The rate certification and supporting documentation must describe the development of the projected benefit costs included in the capitation rates, including:

i. 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.

ii. Any material changes to the data, assumptions, and methodologies used to develop projected benefit costs since the last certification must be described.

B. 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).

i. This section must include:

(a) Any data used or assumptions made in developing projected benefit cost trends, including a description of the sources of those data and assumptions. The descriptions of data and assumptions should include citations whenever possible.

(b) The methodologies used to develop projected benefit trends.

(c) 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.

ii. This section must include the projected benefit cost trends separated into components, specifically:

(a) The projected benefit cost trends should be separated into:

(i) Changes in price (i.e., pricing differences due to different provider reimbursement rates or payment models); and

(ii) changes in utilization (i.e., differences in the amount, duration, or mix of benefits or services provided).

(b) If the actuary did not develop the projected benefit cost trends using price and utilization components, the actuary must describe and justify the method(s) used to develop projected benefit cost trends.

(c) 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).

iii. Variations in the projected benefit cost trends must be explained. Projected benefit cost trends may vary by:

(a) Medicaid populations;

(b) rate cells; or

(c) subsets of benefits within a category of services (e.g., specialty vs. non-specialty drugs).

iv. Any other material adjustments to projected benefit cost trends, including a description of the data, assumptions, and methodologies used to determine those adjustments must be included**.**

v. Any other adjustments to projected benefit costs trends should be described, including:

(a) The impact of managed care on the utilization and the unit costs of health care services; or

(b) Changes to projected benefit costs trend in the rating period outside of regular changes in utilization or unit cost of services.

C. If the projected benefit costs include costs for in lieu of services (i.e., substitutes for State Plan services), the following must be described:

i. The categories of service that contain in lieu of services;

ii. the percentage of cost that in lieu of services represent in each category of service; and

iii. 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. The rate certification must describe how retrospective eligibility periods are accounted for in rate development, including but not limited to:

i. The managed care plan's responsibility to pay for claims incurred during the retroactive eligibility period;

ii. how the claims information are included in the base data;

iii. how the enrollment or exposure information is included in the base data; and

iv. how the capitation rates are adjusted to reflect the retroactive eligibility period, and the assumptions and methodologies used to develop those adjustments.

E. 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).

F. 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:

i. More or fewer state plan benefits covered by Medicaid managed care;

ii. requirements related to payments from health plans to any providers or class of providers;

iii. requirements or conditions of any applicable waivers; or

iv. requirements or conditions of any litigation.

G. 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. Any change not determined by the actuary to be material can be grouped with other non-material changed and described within the rate certification. If this is done, the actuary must give a description of why the changes were not considered material and how they were aggregated into a single adjustment.

4. Pass-Through Payments

A. A pass-through payment is any of the following things:

i. Any amount that the state requires a managed care plan to pay providers for something other than:

(a) A specific service or benefit provided;

(b) an alternative provider payment methodology, which is consistent with previously issued guidance on integrated care models;

(c) a quality incentive payment;

(d) a subcapitated payment arrangement for a specific set of services;

(e) graduate Medical Education (GME) payments; or

(f) Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) wrap around payments.

ii. Any amount added by the State, or any amount required by the State to be added, to the payments from the plans to the providers that is not included in the contracted payment rates between the plans and the providers for a health care service, benefit or something listed in Section 4(A)(i) of this section.

B. The rate certification and supporting documentation must describe all existing pass-through payments included in the rates for this rating period, including:

i. A description of the pass-through payment;

ii. the amount of the pass-through payments, both in total and on a per member per month basis (if applicable);

iii. the providers receiving the pass-through payments;

iv. the financing mechanism for the pass-through payment; and

v. the amount of pass-through payments made to providers in previous years. In general, this should include the same years of historical claims data and financial data used to develop the rates.

C. A common practice in fee-for-service methodologies in Medicaid is to pay providers a supplemental amount beyond the reimbursement rate for the service (e.g., upper payment limit (UPL) payments and disproportionate share hospital (DSH) payments). If states are using a supplemental payment methodology in fee-for-service, it may be reasonable and appropriate to assume higher reimbursements on a per-service basis when looking at the projected benefit costs under managed care in order to ensure that the plan has sufficient capitation rates to cover the expected costs of the enrollees. When incorporating a fee-for-service supplemental payment in the managed care rates, the actuary must describe:

i. A description of the supplemental payment;

ii. the total amount of the supplemental payments;

iii. the providers receiving the supplemental payments;

iv. the methodology that the actuary used to incorporate the supplemental payment into the capitation rates;

v. any payment mechanisms associated with incorporating the supplemental payment into the capitation rates; and

vi. an analysis and certification that the payment mechanism(s) is consistent with Item 5.A of this section.

5. Projected Non-Benefit Costs

A. The rate certification and supporting documentation must describe the development of the projected non-benefit costs included in the capitation rates, including:

i. 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.

ii. Any material changes to the data, assumptions, and methodologies used to develop projected non-benefit costs since the last rate certification.

B. States and actuaries must estimate the projected non-benefit costs for each of the following categories of costs:

i. Administrative costs;

ii. care coordination and care management;

iii. provision for operating or profit margin;

iv. taxes, fees, and assessments; and

v. other material non-benefit costs.

C. CMS recommends that projected non-benefit costs be developed as a per member per month cost by estimating non-benefit costs in common categories of administrative expenses.[1]

D. States and actuaries may calculate projected non-benefit costs as a percentage of benefit costs or the total capitation rate. However, even under this approach CMS recommends estimating non-benefit costs in common categories of administrative expenses to the extent possible.

E. Regarding how to address the Health Insurance Providers Fee (HIPF), CMS issued guidance in October 2014 (Medicaid and CHIP FAQs: Health Insurance Providers Fee

[1] We believe that this approach to developing projected non-benefit costs helps facilitate the longitudinal comparisons of costs over time. Likewise, this approach better connects projected non-benefit costs to various contractual requirements.

for Medicaid Managed Care Plans, http://medicaid.gov/federal-policy-guidance/downloads/faq-10-06-2014.pdf). The rate certification and supporting documentation must:

i. Specifically address how this fee is incorporated into capitation rates.

ii. 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.

iii. 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.

iv. 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.

v. 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.

6. Rate Range Development

A. In cases when the actuary develops and certifies rate ranges on behalf of a state, the rate certification and supporting documentation must describe how the rate ranges were developed, including:

i. Any assumptions for which values vary in order to develop rate ranges;

ii. the values of each of the assumptions used to develop the minimum, the mid-point or best estimate (as applicable), and the maximum of the rate ranges; and

iii. a description of the data, assumptions, and methodologies that were used to develop the values of the assumptions for the minimum, the mid-point or best estimate (as applicable), and the maximum of the rate ranges.

B. The information related to rate range development must be included in either the relevant sections of the rate certification or in a separate section related to specifically to the rate range development. For example, a description of how certain assumptions related to projected benefit costs vary to develop the rate ranges may be included with the description of other information related to projected benefit costs, or may be included in a section that describes all of the assumptions that were varied to develop the rates. The certification index, described in Section I, Item 1.C, should note where these are described.

7. Risk Mitigation, Incentives and Related Contractual Provisions

A. The rate certification and supporting documentation must describe any risk mitigation, incentives, or similar contractual provisions that may affect the rates, rate ranges, or the final net payments to the health plans under the applicable contract.

B. The rate certification and supporting documentation must specifically address:

   i. The risk adjustment model(s) being used to calculate risk scores;

   ii. the specific data, including the source(s) of the data, being used by the risk adjustment model(s);

   iii. how frequently the risk scores are calculated;

   iv. how the risk scores are being used to adjust the capitation rates; and

   v. an attestation that the risk adjustment model is cost neutral. (*See* 42 CFR 438.6(c)(1)(C)(iii) and 438.6(c)(3)(iv).)

C. The rate certification and supporting documentation must indicate if a risk-sharing model is being used to account for the health status of the population in a manner that is not cost neutral (i.e., in a manner that may cause the total projected costs to increase or decrease based on the actual health status of the population). These types of risk-sharing models should only be used prospectively as part of the rate development process and not to adjust the final capitation rates or payments to managed care plans (e.g., estimating how projected changes in the risk of the Medicaid population may effect projected benefit costs). CMS may also consider these 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). CMS prefers to describe this type of adjustment as an "Acuity Adjustment." If an acuity adjustment is being used, the rate certification must include:

   i. The reason that there is significant uncertainty about the health status of the population and the need for an acuity adjustment;

   ii. the risk adjustment or acuity adjustment model(s) being used to calculate acuity adjustment scores;

   iii. the specific data, including the source(s) of the data, being used by the risk adjustment or acuity adjustment model(s);

   iv. the relationship and potential interactions between the acuity adjustment and the risk adjustment;

   v. how frequently the acuity adjustment scores are calculated; and

   vi. a description of how the acuity adjustment scores are being used to adjust the capitation rates.

D. The rate certification and supporting documentation must detail any other risk-sharing arrangements, such as a risk corridor or a large claims pool. This includes:

   i. A rationale for the use of the risk sharing arrangement;

   ii. a detailed description of how the risk-sharing arrangement is implemented; and

   iii. a description of any effect that the risk-sharing arrangements have on the development of the capitation rates.

E. If the contract has a medical loss ratio requirements, such as a minimum medical loss ratio requirement, the rate certification and supporting documentation must include:

   i. A detailed description of, or citation for, the methodology used to calculate the medical loss ratio; and

   ii. a description of the consequences for having a medical loss ratio below the minimum requirements (e.g., financial recovery; contractual penalties).

F. The rate certification and supporting documentation must provide a detailed description of any reinsurance requirements under the contract associated with the rate certification, including a description of any effect that the reinsurance requirements have on the development of the capitation rates.

G. The rate certification and supporting documentation must describe any incentives or withhold amounts in the contract between the state and the health plans. The rate certification must include:

   i. A certification that the incentive payments will not exceed 105% of the certified rates being paid under the contract;

   ii. a description of the percentage of the certified capitation rates being withheld through withhold arrangements;

   iii. an estimate of the percentage of the withheld amount through a withhold arrangement that is expected to be returned and the basis for that determination; and

   iv. a description of any effect that the incentive or withhold arrangements have on the development of the capitation rates.

8. Other Rate Development Considerations

A. In determining whether the rate certification submission and supporting documentation adequately demonstrate that the rates were developed using generally accepted actuarial practices and principles, CMS will consider the following:

   i. 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 judgement and must be included in the rate certification.

ii. Adjustments to the rates or rate ranges that are performed outside of the rate setting process described in the actuarial certification are not considered actuarially sound under 42 CFR §438.6(c).

iii. The final contracted rates must either match the capitation rates or be within the rate ranges in the actuarial certification. This is required in total and for each and every rate cell.

9. Procedures For Rate Certifications for Rate and Contract Amendments

A. CMS requires that the State will submit a new rate certification when the rates or rate ranges change.

B. For contract amendments that do not affect the rates or rate ranges, CMS does not require a new actuarial certification from the State.

C. There are several circumstances when CMS would not require a new actuarial certification:

i. A state changes the capitation rates paid to the plans, but the capitation rates still fall within the certified rate ranges for that rating period and contract.

ii. A state applies risk scores to the capitation rates paid to the plans under a risk adjustment methodology described in the certification for that rating period and contract.

D. CMS reminds states that any time a rate changes for any reason other than application of a 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 new actuarial certification.

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 §438.6 and include managed long-term supports and services (MLTSS). In determining whether 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 supports and services (MLTSS) programs, or for programs that include MLTSS as part of the covered benefits, the actuarial rate certification must provide the information described in Section I of this guidance that is specific to MLTSS.

B. 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. States may take different approaches for rate setting for MLTSS. The two most common approaches are to structure the rate cells:

      (i) By health care status and the level of need of the beneficiaries; or

      (ii) by the long-term care setting that the beneficiary uses.

   (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. States that are currently using a structure that differentiates rates by long-term care setting will need to describe why a blended rate structure is not feasible at this time and CMS will work with the state to move to a blended rate structure in the coming rating periods in order to align with the 2013 guidance around MLTSS programs found here. http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/1115-and-1915b-mltss-guidance.pdf

C. The rate certification must describe the expected effect that managing LTSS has on the utilization and unit costs of services. The certification must describe 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)**.**

D. 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 shall describe how the projected non-benefit costs were developed for populations receiving these services.

E. The rate certification must 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 1902(a)(10)(A)(i)(VIII) 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 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 information 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, the rate certification must describe any data used to develop new adult group rates.

B. For states that have covered the new adult group in Medicaid managed care plans in 2014 and/or 2015, CMS expects the rate certification, as supported by assurances from the State, to describe:

i. Any new data that is available for use in 2016 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 2014 and/or 2015 have differed from assumptions and expectations in previous rate certifications; and

iv. how differences between projected and actual experience in 2014 and/or 2015 have been used to adjust the 2016 rates.

2. Projected Benefit Costs

A. In addition to the guidance for all Medicaid managed care rate certifications described in Section I, 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 2014 and/or 2015:

(a) Any data and experience specific to newly eligible adults covered in 2014 and/or 2015 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 certification.

(c) How assumptions changed from the 2014 and/or 2015 rate certification 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 newly eligible adults;

(v) differences in provider reimbursement rates or provider networks, including any differences between provider reimbursement rates or provider networks for newly eligible adult rates and other Medicaid population rates; and

(vi) other material adjustments to newly eligible adults projected benefit costs.

B. For any state that is covering the new adult group, regardless if they have been covered in 2014 and/or 2015, the following key assumptions related to the new adult group must be included in the rate certification and supporting documentation:

i. Acuity or health status adjustments (in most cases comparing 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 the new adult group rates and other Medicaid population rates; and

vi. other material adjustments to the new adult group projected benefit costs.

C. The rate certification and supporting documentation must describe any changes to the benefit plan offered to the new adult group.

D. 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, 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 2014 and/or 2015, 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 2014 and/or 2015 rate certification 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; and

(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:

(a) Administrative costs;

(b) care coordination and care management;

(c) provision for operating or profit margin;

(d) taxes, fees, and assessments; and

(e) other material non-benefit costs.

4. Final Certified Rates or Rate Ranges

A. In addition to the expectations for all Medicaid managed care rate certifications described in Section I, states that covered the new adult group in Medicaid managed care plans in 2014 and/or 2015 shall provide:

i. A comparison to the final certified rates or rate ranges in the previous rate certification; and

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. States must 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 2014 and/or 2015, the state shall provide:

i. Any changes in the risk mitigation strategy from those used during 2014 and/or 2015;

ii. the rationale for making the change in the risk mitigation strategy; and

iii. any relevant experience, results, or preliminary information available related to the risk mitigation strategy used during 2014 and/or 2015.