Mercer

Adam Sery, FSA, MAAA
Principal

Roger Figueroa, ASA, MAAA
Senior Associate

Government Human Services Consulting
3560 Lenox Road, Suite 2400
Atlanta, GA 30326
www.mercer-government.mercer.com

Mr. Daniel Cocran
Chief Financial Officer
Louisiana Department of Health
Bureau of Health Services Financing
628 North 4th Street
Baton Rouge, LA 70821

November 17, 2021

Subject: Louisiana Medicaid Dental Benefit Program Capitation Rate Certification for the Period January 1, 2022 through December 31, 2022

Dear Mr. Cocran:

In partnership with the State of Louisiana (State), Mercer Government Human Services Consulting (Mercer), as part of Mercer Health & Benefits LLC, has developed statewide actuarially sound[1] capitation rates for the Louisiana Medicaid Dental Benefit Program (DBP). These rates are applicable for the contract period January 1, 2022 through December 31, 2022.

This document presents the rate development and provides the certification of actuarial soundness required by 42 CFR §438.4. This rate development process was based on managed care encounter data and financial data provided by Managed Care of North America (MCNA) Dental, the current DBP contractor. It resulted in the development of actuarially sound rates for each rate cell. The final capitation rates are summarized in Table 1-1 and represent payment in full for the covered services.

Dental Capitation Rates

In the Certification of Rates section, Mercer certifies the following rates, which are applicable statewide.

[1] Actuarially Sound/Actuarial Soundness — Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes.

Reference: http://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf.

Tale 1-1: Dental Capitation Rates

January 1, 2022 through December 31, 2022	
Rate Cell Description	**Monthly Capitation Rate Per Member**
LaCHIP Affordable Plan	$26.50
Medicaid Child/CHIP	$21.32
Medicaid Adult	$1.34
Medicaid Expansion Child	$19.71
Medicaid Expansion Adult	$0.91

Table 1-2 compares the new capitation rates to those established for the prior period (January 1, 2021 through December 31, 2021).

Table 1-2: Rate Change Summary

Rate Cell	Jan 2021–Dec 2021 Rates	Jan 2022–Dec 2022 Rates	% Change
	[A]	[B]	[C] = [B]/[A] - 1
LaCHIP Affordable Plan	$28.08	$26.50	-5.63%
Medicaid Child/CHIP	$23.14	$21.32	-7.87%
Medicaid Adult	$1.84	$1.34	-27.17%
Medicaid Expansion Child	$22.30	$19.71	-11.61%
Medicaid Expansion Adult	$1.11	$0.91	-18.02%

For the capitation rates for the contract period January 1, 2022 through December 31, 2022, the main drivers of the rate change from the prior rating period were as follows:

- Experience change due to shifting of the base data period
- Adjusted trend for all populations

Managed Care Rate Development Methodology

Overview

Effective July 1, 2014, Louisiana implemented a managed DBP for Louisiana Children's Health Insurance Program (LaCHIP) Affordable Plan, Medicaid Children (including the primary LaCHIP

program), and Medicaid Adult populations. The DBP covers preventive dental services for eligible members younger than age 21 and adult denture benefits for eligible members aged 21 and older. The managed DBP is expected to efficiently manage service costs and utilization, improve access to essential specialty dental services, and increase outreach and education to promote healthy dental behavior.

This letter provides the requisite documentation to support the Centers for Medicare & Medicaid Services' (CMS') rate review process. This letter follows the general outline of the CMS 2021-2022 Medicaid Managed Care Rate Development Guide (RDG) published in June 2021. These actuarially sound dental capitation rates are based upon the State Plan-covered services only. Base period dental claims data were analyzed, completed, and trended. Adjustments were applied, as appropriate, to reflect programmatic changes to the State Plan that affect the base period data and the contract period. A prepaid ambulatory health plan (PAHP) administrative load assumption was developed and included. Each of these rating elements is discussed in detail below.

Covered Populations

In general, the DBP covers most Medicaid eligible, LaCHIP and the LaCHIP Affordable Plan populations including full dual eligibles. The LaCHIP population was included in the Medicaid Children category for the dental capitation rates.

Effective July 1, 2016, Louisiana expanded Medicaid coverage under the Affordable Care Act. The Expansion population was also included in the DBP covered populations.

The DBP non-covered populations are shown in Appendix A.

Rate Cell Structure

There are five distinct rate cells for the DBP program, as listed below in Table 2.

Table 2: Rate Cell Structure

Rate Cell	Program	Age Range
LaCHIP Affordable Plan	Non-Expansion	0-20
Medicaid Child/CHIP	Non-Expansion	0-20
Medicaid Adult	Non-Expansion	21 and above
Medicaid Expansion Child	Expansion	19-20
Medicaid Expansion Adult	Expansion	21-64

Base Data

For rate setting in the contract period January 1, 2022 through December 31, 2022, Mercer relied on Louisiana Medicaid eligibility and enrollment data and managed care encounter data from calendar year (CY) 2019.

Mercer reviewed the data provided by the State for consistency and reasonableness and determined the data is appropriate for the purpose of setting capitation rates for the DBP. Mercer confirmed the services included in this historical experience are State Plan-covered services only.

Retroactive Eligibility

Per the State, membership and claims incurred for covered services rendered prior to enrollment and during any retroactive period up to 12 months of eligibility are covered in the DBP. These claims and eligibility are included in the base data.

Institution of Mental Diseases

The base data was adjusted to remove member months (MMs) and dental claims associated with enrollees aged 21-64 who stayed in an institution of mental diseases (IMD) for more than 15 days. The adjustment reduced the Medicaid Adult base MMs from 3,740,816 to 3,740,331 for CY 2019. The Medicaid Expansion Adult base MMs for CY 2019 decreased from 5,302,992 to 5,302,715 for this adjustment.

The base data had no dental claims associated with enrollees aged 21-64 who stayed in an IMD for more than 15 days, so no adjustment was necessary.

Table 3-1: IMD MMs Adjustment

Rate Cell	Base MMs (Includes IMD)	IMD Adjusted MMs	% Change
	[A]	[B]	[C] = [B]/[A] - 1
Medicaid Adult	3,740,816	3,740,331	-0.01%
Medicaid Expansion Adult	5,302,992	5,302,715	-0.01%

Non-Claims and Financial Reporting Adjustment

The non-claims and financial reporting (NCFR) adjustment was developed by comparing encounter data from the Medicaid Management Information System to financial information provided by MCNA. The adjustment was based on detailed quarterly reported financial data provided by MCNA. The year-end financial report is reviewed by the MCO's auditors using agreed upon procedures. The audit report accounts for any changes or recommendations recommended by the auditor. Additionally, the financial data is compared to the MCO's annual statutory filing using standards from the National Association of Insurance Commissioners, commonly known as the Orange Blank, to check for accuracy and completeness.

The adjustment was developed and applied with separate Child and Adult groupings. The Child grouping combines Medicaid Child/CHIP, Medicaid Expansion Child, and LaCHIP Affordable Plan rate cells. The Adult grouping combines Medicaid Adult and Medicaid Expansion Adult rate cells. The adjustment resulted in an increase to the base per member per month (PMPM) of 1.91% and 5.25% for Child and Adult groups, respectively. The total increase to the overall CY 2019 base PMPM was 2.06%.

Table 3-2: Non-Claims and Financial Reporting

Rate Cell	Base PMPM	NCFR Adjusted PMPM	% Change
	[A]	[B]	[C] = [B]/[A] - 1
Medicaid Child Groups CY 2019	$14.75	$15.03	1.91%
Medicaid Adult Groups CY 2019	$0.76	$0.80	5.25%
Total CY 2019	**$7.90**	**$8.06**	**2.06%**

Completion Factors

The encounter data included claims for dates of service from January 1, 2019 through December 30, 2019, and payments through March 31, 2021. Mercer estimated and adjusted for the remaining liability associated with incurred but not reported claims for CY 2019. The overall adjustment applied was 0.07% for the CY 2019 claims.

Fraud and Abuse Adjustment

Fraud and abuse recoveries were included in the financial reports. These recoveries were included in the development of the under-reporting adjustment.

Co-Payments and Third Party Liability

An adjustment for co-payments was not necessary for this analysis because both the Legacy Medicaid program and the DBP are not subject to co-payments. Recoveries associated with third party liability and subrogation have been removed from claims by utilizing only MCO paid amounts.

Fee Schedule Changes

The capitation rates reflect changes in covered services' fee schedules and unit costs between the base period and the contract period.

Early and Periodic Screening & Diagnosis Treatment Dental Program Fee Schedule Update

Effective July 1, 2019, LDH released an updated Early and Periodic Screening & Diagnosis Treatment (EPSDT) Dental program fee schedule, which can be located on LDH's website[2]. The dental projected cost was adjusted to reflect changes in the fee schedule in the base period using the fee schedule effective July 1, 2019. The impact of the EPSDT fee schedule change can be seen below in Table 3-3.

Table 3-3: Fee Schedule Changes

EPSDT Dental Program Fee Change Impact				Impact as % of	
Time Period	Rate Cell	Historical Cost	Fee Change Impact	Historical Cost	All Services Cost
CY 2019	LaCHIP Affordable Plan	$109,773	$14,409	13.13%	2.85%
CY 2019	Medicaid Child/CHIP	$28,561,644	$2,891,272	10.12%	2.20%
CY 2019	Medicaid Adult	$0	$0	0.00%	0.00%

[2] https://www.lamedicaid.com/provweb1/fee_schedules/feeschedulesindex.htm

EPSDT Dental Program Fee Change Impact				Impact as % of	
Time Period	Rate Cell	Historical Cost	Fee Change Impact	Historical Cost	All Services Cost
CY 2019	Medicaid Expansion Child	$3,068,247	$295,399	9.63%	4.31%
CY 2019	Medicaid Expansion Adult	$0	$0	0.00%	0.00%
Total		**$31,739,664**	**$3,201,080**	**10.09%**	**2.20%**

Trend Adjustments

Trend is an estimate of the change in the expected frequency and intensity of incurred services over a finite period of time. A trend factor is necessary to estimate the cost of providing health care services in a future period. To develop the trend factors, Mercer primarily considered historical experience based on Louisiana dental encounter data incurred through December 2020. Mercer also reviewed dental trend benchmarks in other state Medicaid programs and commercial dental managed care programs prior to the COVID-19 pandemic.

With the utilization of dental services being impacted due to the ongoing pandemic, Mercer still expects some impact to dental utilization to continue during rate year 2022. As a result, downward trend adjustments are applied for all of the covered populations. The estimated PMPM trends are shown below in Table 4.

Table 4: Trend

Rate Cell	Total PMPM Annual Trend
LaCHIP Affordable Plan	-2.00%
Medicaid Child/CHIP	-1.50%
Medicaid Adult	-5.75%
Medicaid Expansion Child	-1.50%
Medicaid Expansion Adult	-3.50%

Programmatic Changes

Program change adjustments recognize the impact of benefit or eligibility changes occurring after the start of the base data period. CMS requires the rate-setting methodology used to determine actuarially sound rate ranges incorporates the results of any programmatic changes that have taken place, or are anticipated to take place, between the start of the base period and the conclusion of the contract period.

Intermediate Care Facilities for Individuals with Intellectual Disabilities Population

Effective January 1, 2021, the Louisiana Medicaid DBP will begin to cover Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) populations. The dental projected cost was adjusted to reflect the changes between the base period and the current period, which includes the ICF/IID populations. Table 5-1 below shows the impact of the ICD/IID population coverage as a percentage of historical cost.

Table 5-1: ICF/IID Populations Impact

Time Period	Rate Cell	Historical PMPM	Adjusted PMPM	Impact As %
CY 2019	LaCHIP Affordable Plan	$18.49	$18.49	0.00%
CY 2019	Medicaid Child/CHIP	$14.81	$14.80	-0.02%
CY 2019	Medicaid Adult	$0.99	$0.97	-1.23%
CY 2019	Medicaid Expansion Child	$13.55	$13.55	0.00%
CY 2019	Medicaid Expansion Adult	$0.60	$0.60	0.00%
Total		**$7.90**	**$7.88**	**-0.26%**

Full Medicaid Pricing

Effective January 1, 2020, LDH implemented a program change to increase payments for dental providers. This change required the use of a full Medicaid pricing (FMP) adjustment in the calculation of payments for dental services provided by MCNA. LDH expects this rate increase will lead to increased payments to those providers contracted with MCNA to maintain and increase access to dental services to the enrolled Medicaid populations. Mercer calculated FMP payments by computing the difference between paid claim amounts and what would have been paid under the community rate, which is defined as the rate paid by the MCNA National Preferred Provider Organization Network Specialist Fee for the same service. This methodology is designed to bring the payments for the dental services to the commercial specialist rate level. Mercer calculated the FMP adjustment by using the units of service from the base data and community rate provided by LDH. Table 5-2 shows the impact of FMP as a percentage of the historical cost.

Table 5-2: FMP

Time Period	Rate Cell	Historical PMPM	FMP PMPM	Impact As %
CY 2019	LaCHIP Affordable Plan	$18.49	$5.52	30.43%
CY 2019	Medicaid Child/CHIP	$14.81	$4.37	29.61%
CY 2019	Medicaid Adult	$0.99	$0.36	40.55%
CY 2019	Medicaid Expansion Child	$13.55	$3.87	28.67%

Time Period	Rate Cell	Historical PMPM	FMP PMPM	Impact As %
CY 2019	Medicaid Expansion Adult	$0.60	$0.25	43.20%
Total		**$7.90**	**$2.31**	**30.14%**

Special Contract Provision Related to Payment

Minimum Medical Loss Ratio

In accordance with the DBP contractor Financial Reporting Guide published by LDH, the DBP contractor shall provide a medical loss ratio (MLR) report following the end of the MLR reporting period, which shall be the same as the contract period. An MLR shall be reported separately for Non-Expansion and Expansion populations, including all dental services covered under the contract. If the aggregate MLR (cost for dental care benefits and services and specified quality expenditures) is less than 85.00%, the contractor shall refund LDH the difference.

Capitation rates are developed in a way the DBP contractor would reasonably achieve an MLR standard greater than 85.00%, as calculated under 42 CFR §438.8. The capitation rates are adequate for reasonable, appropriate and attainable non-benefit costs.

Non-Medical Expense Load

The proposed capitation rates shown above include provision for dental PAHP administration and underwriting gain. Mercer relied upon its professional experience in working with numerous commercially-managed dental plans and state Medicaid programs in determining appropriate administrative expenses. The loads for administrative expenses and underwriting gain are calculated as percentages of the capitation rate net of premium tax. Finally, the capitation rates include a load for the State’s premium tax, which is calculated as a percentage of the final capitation rate.

The proposed capitation rates assume a 9.00% load for administrative expenses, 2.00% underwriting gain, and 2.25% premium tax for the January 2022 through December 2022 contract period. In total, the overall non-medical expense load applied to the rates is 13.00%.

Federal Health Insurance Provider Fee

Louisiana recognizes expenses related to the Health Insurance Provider Fee (HIPF) through an adjustment to the data year premiums. Due to the federal repeal of the HIPF for calendar years effective after December 31, 2020, a HIPF adjustment is not applicable to the capitation rates for the contract period January 1, 2022 through December 31, 2022.

Certification of Rates

This certification assumes items in the Medicaid State Plan or waiver, as well as the DBP MCO contract, have been approved by CMS.

In preparing the capitation rates for the contract period January 1, 2022 through December 31, 2022, Mercer used and relied upon enrollment, eligibility and encounter data, fee schedule benefit design and financial data and information supplied by the State, its fiscal agent, and its contractor. The State, its fiscal agent, and its contractor are responsible for the validity and completeness of this supplied data and information. Mercer reviewed the summarized data and information for internal consistency and reasonableness but did not audit it. In Mercer's opinion, it is appropriate for the intended rate-setting purposes. However, if the data and information is incomplete or inaccurate, the values shown in this report may differ significantly from values that would be obtained with accurate and complete information; this may require a later revision to this report.

Because modeling all aspects of a situation or scenario is not possible or practical, Mercer may use summary information, estimates, or simplifications of calculations to facilitate the modeling of future events in an efficient and cost-effective manner. Mercer may also exclude factors or data that are immaterial in its judgment. Use of such simplifying techniques does not, in Mercer's judgment, affect the reasonableness, appropriateness, or attainability of the results for the Medicaid program. Actuarial assumptions may also be changed from one certification period to the next because of changes in mandated requirements, program experience, changes in expectations about the future, and other factors. A change in assumptions is not an indication that prior assumptions were unreasonable, inappropriate, or unattainable when they were made.

Mercer certifies that the rates shown in Table 1-1 were developed in accordance with generally accepted actuarial practices and principles, and are appropriate for the Medicaid covered populations and services under the managed care contract. Benefit plan premium rates are "actuarially sound" if, for the business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows and investment income. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Rates developed by Mercer are actuarial projections of future contingent events. All estimates are based upon the information and data available at a point in time, and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely, and potentially wide, range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other

party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use. Actual DBP contractor costs will differ from these projections. Mercer has developed these rates on behalf of the State to demonstrate compliance with the CMS requirements under 42 CFR §438.4 and accordance with applicable law and regulations. Use of these rates for any purpose beyond that stated may not be appropriate.

The DBP contractor is advised that the use of the rates may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of the rates by the DBP contractor for any purpose. Mercer recommends that any health plan considering contracting with the State should analyze its own projected dental expense, administrative expense, and any other premium needs for comparison to the rates before deciding whether to contract with the State.

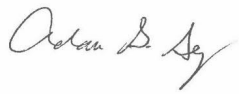
The State understands that Mercer is not engaged in the practice of law, or in providing advice on taxation matters. This report, which may include commenting on legal or taxation issues or regulations, does not constitute and is not a substitute for legal or taxation advice. Accordingly, Mercer recommends that the State secure the advice of competent legal and taxation counsel with respect to any legal or taxation matters related to this report or otherwise.

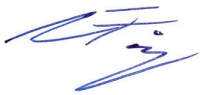
This certification letter assumes the reader is familiar with the Louisiana DBP, Medicaid eligibility rules, and actuarial rating techniques. It has been prepared exclusively for the State and CMS, and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these results. Mercer is not responsible for, and expressly disclaims liability for, any reliance on this report by third parties.

The State agrees to notify Mercer within 30 days of receipt of this report if it disagrees with anything contained in this report or is aware of any information or data that would affect the results of this report that has not been communicated or provided to Mercer or incorporated herein. The report will be deemed final and acceptable to the State if nothing is received by Mercer within such 30-day period.

If you have any questions or comments on the assumptions or methodology, please contact Adam Sery at +1 612 802 0780 or Roger Figueroa at +1 470 548 8862.

Sincerely,





Adam Sery FSA, MAAA
Principal

Roger Figueroa, ASA, MAAA
Senior Associate

Copy:
Brandon Bueche, Program Management – LDH
Bogdan Constantin, Managed Care Finance – LDH
Patrick Gillies, Medicaid Director – LDH
Marisa Naquin, Managed Care Finance – LDH
F. Ronald Ogborne III, FSA, MAAA, CERA, Partner – Mercer

Appendix A

Type Case	Type Case Description	Aid Category	Aid Category Description	Excluded Non-Expansion Populations?
001	SSI Conversion / Refugee Cash Assistance (RCA) / LIFC Basic	11	Hurricane Evacuees	Yes
002	Deemed Eligible	11	Hurricane Evacuees	Yes
005	SSI/LTC	11	Hurricane Evacuees	Yes
007	LACHIP Phase 1	11	Hurricane Evacuees	Yes
008	PAP - Prohibited AFDC Provisions	11	Hurricane Evacuees	Yes
009	LIFC - Unemployed Parent / CHAMP	11	Hurricane Evacuees	Yes
013	CHAMP Pregnant Woman (to 133% of FPIG)	11	Hurricane Evacuees	Yes
014	CHAMP Child	11	Hurricane Evacuees	Yes
015	LACHIP Phase 2	11	Hurricane Evacuees	Yes
020	Regular MNP (Medically Needy Program)	11	Hurricane Evacuees	Yes
021	Spend-Down MNP	11	Hurricane Evacuees	Yes
025	LTC Spend-Down MNP	11	Hurricane Evacuees	Yes
027	EDA Waiver	11	Hurricane Evacuees	Yes
028	Tuberculosis (TB)	20	TB	Yes
040	SLMB (Specified Low-Income Medicare Beneficiary)	01	Aged	Yes
040	SLMB (Specified Low-Income Medicare Beneficiary)	02	Blind	Yes

Type Case	Type Case Description	Aid Category	Aid Category Description	Excluded Non-Expansion Populations?
040	SLMB (Specified Low-Income Medicare Beneficiary)	04	Disabled	Yes
047	Illegal/Ineligible Aliens Emergency Services	01	Aged	Yes
047	Illegal/Ineligible Aliens Emergency Services	03	Families and Children	Yes
047	Illegal/Ineligible Aliens Emergency Services	04	Disabled	Yes
047	Illegal/Ineligible Aliens Emergency Services	11	Hurricane Evacuees	Yes
048	QI-1 (Qualified Individual - 1)	01	Aged	Yes
048	QI-1 (Qualified Individual - 1)	02	Blind	Yes
048	QI-1 (Qualified Individual - 1)	04	Disabled	Yes
049	QI-2 (Qualified Individual - 2) (Program terminated 12/31/2002)	01	Aged	Yes
049	QI-2 (Qualified Individual - 2) (Program terminated 12/31/2002)	04	Disabled	Yes
050	PICKLE	11	Hurricane Evacuees	Yes
053	CHAMP Pregnant Woman Expansion (to 185% FPIG)	11	Hurricane Evacuees	Yes
055	LACHIP Phase 3	11	Hurricane Evacuees	Yes
059	Disabled Adult Child	11	Hurricane Evacuees	Yes
063	LTC Co-Insurance	01	Aged	Yes
063	LTC Co-Insurance	02	Blind	Yes
063	LTC Co-Insurance	04	Disabled	Yes
063	LTC Co-Insurance	11	Hurricane Evacuees	Yes
083	Acute Care Hospitals (LOS > 30 days)	11	Hurricane Evacuees	Yes

Type Case	Type Case Description	Aid Category	Aid Category Description	Excluded Non-Expansion Populations?
085	Grant Review	03	Families and Children	Yes
086	Forced Benefits	04	Disabled	Yes
088	Medicaid Buy-In Working Disabled (Medicaid Purchase Plan)	11	Hurricane Evacuees	Yes
090	LTC (Long-Term Care)	11	Hurricane Evacuees	Yes
093	DD Waiver	03	Families and Children	Yes
094	QDWI	04	Disabled	Yes
095	QMB (Qualified Medicare Beneficiary)	17	QMB	Yes
100	PACE SSI	01	Aged	Yes
100	PACE SSI	02	Blind	Yes
100	PACE SSI	04	Disabled	Yes
101	PACE SSI-related	01	Aged	Yes
101	PACE SSI-related	02	Blind	Yes
101	PACE SSI-related	04	Disabled	Yes
102	GNOCHC Adult Parent	30	Non Traditional	Yes
103	GNOCHC Childless Adult	30	Non Traditional	Yes
104	Pregnant women with income greater than 118% of FPL and less than or equal to 133% of FPL	11	Hurricane Evacuees	Yes
115	Family Planning, Previous LAMOMS eligibility	40	Family Planning	Yes
115	HPE Family Planning	16	Presumptive Eligible	Yes
116	Family Planning, New eligibility / Non LA MOM	40	Family Planning	Yes
116	HPE Family Planning	16	Presumptive Eligible	Yes

Type Case	Type Case Description	Aid Category	Aid Category Description	Excluded Non-Expansion Populations?
132	Spend-Down Denial of Payment/Late Packet	01	Aged	Yes
132	Spend-Down Denial of Payment/Late Packet	02	Blind	Yes
132	Spend-Down Denial of Payment/Late Packet	04	Disabled	Yes
178	Disabled Adults authorized for special hurricane Katrina assistance	11	Hurricane Evacuees	Yes
201	LBHP - Adult 1915(i)	01	LBHP	Yes
201	LBHP - Adult 1915(i)	02	LBHP	Yes
201	LBHP - Adult 1915(i)	03	LBHP	Yes
201	LBHP - Adult 1915(i)	04	LBHP	Yes
205	LBHP - Adult 1915(i)	01	LBHP	Yes
205	LBHP - Adult 1915(i)	02	LBHP	Yes
205	LBHP - Adult 1915(i)	03	LBHP	Yes
205	LBHP - Adult 1915(i)	04	LBHP	Yes
212	Family Planning/Take Charge Transition	03	Family Planning	Yes
212	HPE Family Planning Elig Options	16	Presumptive Eligible	Yes

Appendix B

Table 1

			Base Data Adjustments			
	[A]	[B]	[C]	[D]	[E]	[F]
Rate Cell Description	CY 2019 MMs	CY 2019 Base PMPM	Non-Claims and Financial Reporting	IBNR	7/1/19 Fee Schedule Change	Adjusted Base PMPM
LaCHIP Affordable Plan	27,330	$ 18.49	1.91%	0.05%	2.85%	$ 19.39
Medicaid Child/CHIP	8,882,809	$ 14.81	1.91%	0.06%	2.20%	$ 15.43
Medicaid Adult	3,740,331	$ 0.99	5.25%	0.18%	0.00%	$ 1.04
Medicaid Expansion Child	506,092	$ 13.55	1.91%	0.06%	4.31%	$ 14.41
Medicaid Expansion Adult	5,302,715	$ 0.60	5.25%	0.18%	0.00%	$ 0.64
Total	18,459,277	$ 7.90	2.06%	0.07%	2.19%	$ 8.24

Notes:

[F] = [B] x (1 + [C]) x (1 + [D]) x (1 + [E])

Table 2

	Projected Benefit							
	[G]	[H]	[I]	[J]	[K]	[L]	[M]	[N]
Rate Cell Description	Adjusted Base PMPM	Annual Trend	Trend Months	Trended PMPM	ICF/IID Adjustment	Prospective Adjustment	FMP Add-on	Program Changes Adjusted PMPM
LaCHIP Affordable Plan	$ 19.39	-2.00%	36	$ 18.25	0.00%	0.00%	$ 5.40	$ 23.65
Medicaid Child/CHIP	$ 15.43	-1.50%	36	$ 14.75	-0.02%	0.00%	$ 4.27	$ 19.01
Medicaid Adult	$ 1.04	-5.75%	36	$ 0.87	-1.23%	0.00%	$ 0.35	$ 1.21
Medicaid Expansion Child	$ 14.41	-1.50%	36	$ 13.77	0.00%	0.00%	$ 3.79	$ 17.56
Medicaid Expansion Adult	$ 0.64	-3.50%	36	$ 0.57	0.00%	0.00%	$ 0.25	$ 0.82
Total	**$ 8.07**	**-1.64%**	**36**	**$ 7.68**	**-0.05%**	**-0.05%**	**$ 2.26**	**$ 9.93**

Notes

Total Adjusted Base PMPM [G] is based on projected enrollment mix for CY 2022

[J] = [G] x (1 + [H])^([I] / 12)

[N] = [J] x (1 + [K]) x (1 + [L]) + [M]

Table 3

	Retention Load					
	[O]	[P]	[Q]	[R]	[S]	[T]
Rate Cell Description	Admin %	Underwriting Gain	Premium Tax	Total	FMP Add-on	Final Loaded Rate
LaCHIP Affordable Plan	9.00%	2.00%	2.25%	13.00%	$ 5.52	$ 26.50
Medicaid Child/CHIP	9.00%	2.00%	2.25%	13.00%	$ 4.37	$ 21.32
Medicaid Adult	9.00%	2.00%	2.25%	13.00%	$ 0.36	$ 1.34
Medicaid Expansion Child	9.00%	2.00%	2.25%	13.00%	$ 3.87	$ 19.71
Medicaid Expansion Adult	9.00%	2.00%	2.25%	13.00%	$ 0.25	$ 0.91
Total	**9.00%**	**2.00%**	**2.25%**	**13.00%**	**$ 2.31**	**$ 11.13**

Notes

[R] = 1 - (1 - ([O] + [P])) x (1 - [Q])

[S] = [M] / (1 - [R])

[T] = ([N] - [M]) / (1 - R]) + [S]

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July 2021–June 2022 Medicaid Managed Care Rate Development Guide

Louisiana — January 1, 2022–December 31, 2022

Section I. Medicaid Managed Care Rates

1. General Information

A. Rate Development Standards

i. Unless otherwise stated, all standards and documentation expectations outlined in this rate development guide for capitation rates also apply for the development of the upper and lower bounds of rate ranges, in accordance with 42 C.F.R. § 438.4(c).

ii. Rate certifications must be done for a 12-month rating period.[3]

iii. In accordance with 42 C.F.R. §§ 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 C.F.R. § 438.2, who certifies that the final capitation rates meet the standards in 42 C.F.R. §§ 438.3(c), 438.3(e), 438.4, 438.5, 438.6, and 438.7.

b. The final and certified capitation rates or rate ranges for all rate cells in accordance with 42 C.F.R. § 438.4(b)(4) or § 438.4(c) for all regions (as applicable). Additionally, the contract must specify the final capitation rate(s) in accordance with 42 C.F.R. § 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):

[3] Per 42 C.F.R § 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.

Section I. Medicaid Managed Care Rates

1. General Information

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 plan(s) included in the rate development (e.g., type means managed care organization(s), prepaid inpatient health plan(s), or prepaid ambulatory health plan(s)).
   B. A general description or list of the benefits that are required to be provided by the managed care plan(s) (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, provided on a non-risk basis by the managed care plan(s), or that are new to the managed care program in the covered rating period.
   C. The geographic 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 plan(s) is voluntary or mandatory).

v. A summary of the special contract provisions related to payment described in 42 C.F.R. § 438.6 (e.g., risk-sharing mechanisms, incentive arrangements, withhold arrangements, state directed payments,[4] pass-through payments, and payments to MCOs and PIHPs for enrollees that are a patient in an Institution of Mental Disease (IMD)).[5]

vi. If the actuary is certifying rates (not rate ranges) and the state and its actuary determine that a retroactive adjustment to the capitation rates is necessary, these retroactive adjustments must be certified by an actuary in a revised rate certification (CMS would accept a new rate certification or rate amendment)[6] and submitted as a contract amendment in accordance with 42 C.F.R. § 438.7(c)(2).[7] The revisions to the rate certification must:
   A. Describe the rationale for the adjustment;

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[4] State direction of managed care plan expenditures under the contract (e.g., value-based purchasing arrangements, multi-player initiatives, quality/performance incentive programs, and all fee schedules) must meet the requirements in 42 C.F.R. § 438.6(c) and receive prior approval before implementation.
[5] Additional requirements in 42 C.F.R. § 438.6 apply to the various types of special contract provisions; see Section I, Item 4, for more discussion.
[6] The rate guide utilizes the term “rate amendment” throughout this guide to reference an amendment to the initial rate certification.
[7] In accordance with 42 C.F.R. § 438.4(C)(2)(ii), States that use rate ranges are not permitted to modify the capitation rates under 438.7(c)(3).

Section I. Medicaid Managed Care Rates

1. General Information

B. Describe the data, assumptions and methodologies used to develop the magnitude of the adjustment;

C. Describe whether the state adjusted rates in the rating period by a *de minimis* amount in accordance with 42 C.F.R § 438.7(c)(3) prior to the submission of the rate amendment; and

D. Address and account for all differences from the most recently certified rates.

iv. Any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations must be based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations. Any differences in the assumptions, methodologies, or factors used to develop capitation rates must not vary with the rate of Federal financial participation (FFP) associated with the covered populations in a manner that increases Federal costs. The determination that differences in the assumptions, methodologies, or factors used to develop capitation rates for MCOs, PIHPs, and PAHPs increase Federal costs and vary with the rate of FFP associated with the covered populations must be evaluated for the entire managed care program and include all managed care contracts for all covered populations.[8]

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

vi. The assumptions used for development of the capitation rates must be consistent with the effective dates of changes to the Medicaid managed care program (including but not limited to eligibility, benefits, payment rate requirements, incentive programs, and program initiatives).

vii. 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 C.F.R. § 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 C.F.R. § 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.

viii. In accordance with 42 C.F.R. § 438.4(c), the State and its actuary may develop and certify a range of capitation rates per rate cell as actuarially sound, when all of the following conditions are met:

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[8] In accordance with 42 C.F.R § 438.4(b)(1) and 438.7(d), CMS may require a State to provide written documentation and justification that any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations or contracts represent actual cost differences based on the characteristics and mix of covered services or the covered populations.

Section I. Medicaid Managed Care Rates

1. General Information

a. The rate certification identifies and justifies the assumptions, data, and methodologies specific to both the upper and lower bounds of the rate range.

b. Both the upper and lower bounds of the rate range must be certified as actuarially sound consistent with the requirements of 42 C.F.R. § 438.4.

c. The upper bound of the rate range does not exceed the lower bound of the rate range multiplied by 1.05.

d. The rate certification documents the State's criteria for paying MCOs, PIHPs, and PAHPs at different points within the rate range.

e. The State does not use as a criterion for paying MCOs, PIHPs, and PAHPs at different points within the rate range any of the following:[9]

   i. The willingness or agreement of the MCOs, PIHPs, or PAHPs or their network providers to enter into, or adhere to, intergovernmental transfer (IGT) agreements; or

   ii. The amount of funding the MCOs, PIHPs, or PAHPs or their network providers provide through IGT agreements.

ix. When a State develops and certifies a range of capitation rates per rate cell as actuarially sound consistent with 42 C.F.R. § 438.4(c), the State must:

a. Document the capitation rates, prior to the start of the rating period, for the MCOs, PHIPs, and PAHPs at points within the rate range, consistent with 42 C.F.R. § 438.4(c)(1)(iv).

b. Not modify the capitation rates under 42 C.F.R. § 438.7(c)(3).

c. Not modify the capitation rates within the rate range, unless the State is increasing or decreasing the capitation rate per rate cell within the rate range up to 1 percent during the rating period. However, any changes of the capitation rate within the permissible 1 percent range must be consistent with a modification of the contract as required in 42 C.F.R. § 438.3(c) and are subject to requirements of 42 C.F.R. § 438.4(b)(1). Any modification to the capitation rates within the rate range greater than the permissible 1 percent range will require the State to provide a revised rate certification for CMS approval, which demonstrates that:

   i. The criteria in 42 C.F.R. § 438.4(c)(1)(iv), as described in the initial rate certification, were not applied accurately;

   ii. There was a material error in the data, assumptions, or methodologies used to develop the initial rate certification and that the modifications are necessary to correct the error; or

   iii. Other adjustments are appropriate and reasonable to account for programmatic changes.

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[9] The state's criteria for paying managed care plans at different points within the rate range, must comply with the prohibition in 42 C.F.R.§ 438.4(c)(1)(v) and other applicable legal authority.

Section I. Medicaid Managed Care Rates

1. General Information

d. Post on the website, as required in 42 C.F.R. § 438.10(c)(3), the following information prior to executing a managed care contract or contract amendment that includes or modifies a rate range:
   i. The upper and lower bounds of each rate cell;
   ii. A description of all assumptions that vary between the upper and lower bounds of each rate cell, including for the assumptions that vary, the specific assumptions used for the upper and lower bounds of each rate cell; and
   iii. A description of the data and methodologies that vary between the upper and lower bounds of each rate cell, including for the data and methodologies that vary, the specific data and methodologies used for the upper and lower bounds of each rate cell.

x. 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 and consistent with the regulatory requirements, CMS will consider whether the submission demonstrates the following:
   a. All adjustments to the capitation rates or to any portion of the capitation rates referenced in 42 C.F.R. §§ 438.5(b)(4) and 438.5(f) must reflect reasonable, appropriate, and attainable costs in the actuary's judgement 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 C.F.R. § 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 C.F.R. §§ 438.7(c) and 438.4(c)(2)(i), the final contracted rates in each cell must match the capitation rates or, for the rate ranges that are approvable under 42 C.F.R. § 438.4(c), be within rate ranges in the rate certification. This is required in total and for each and every rate cell.

xi. Rates must be certified for all time periods for 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.

xii. CMS expects that states and their actuaries will evaluate how the capitations rates should account for the direct and indirect impacts of the COVID-19 public health emergency. States and their actuaries should evaluate state specific, and other applicable national or regional data that is available and applicable for determining how to address the COVID-19 public health emergency in rate setting. CMS recommends all states implement a 2-sided risk mitigation strategy for rating periods impacted by the public health emergency. Please refer to the CMCS Informational Bulleting published on May 14, 2020 and COVID Frequently Asked Questions for State Medicaid and CHIP Agencies for further information regarding rate development and risk mitigation considerations around the COVID-19 public health emergency. The state must ensure that it complies with the requirements in 42

Section I. Medicaid Managed Care Rates

1. General Information

C.F.R. § 438.6(b)(1), including the risk mitigation strategy must be documented in the contract and rate certification documents for the rating period prior to the start of the rating period.

xiii. Procedures for rate certifications for rate and contract amendments, include:

a. If a state intend to claim FFP for capitation rates, the state must comply with the time limit for filing claims for FFP specified in the section 1132 of the Act and implementing regulations at 45 C.F.R. part 95. States should timely submit rate certifications to CMS to help mitigate timely filing concerns.

b. If the actuary is certifying rates (and not rate ranges), the state must submit a revised rate certification when the rates change, except for changes permitted as specified in 42 C.F.R. § 438.4(c) or 42 C.F.R. § 438.7(c)(3).[10] In accordance with 42 C.F.R. § 438.4(c)(2)(ii), States that use rate ranges are not permitted to modify the capitation rates under 438.7(c)(3).[11] CMS standards for a revised rate certification if the state and its actuary determine that changes are needed within the rate range during the rate year are outlined in Section I, Item 1.A.ix.c of this rate guide.

c. For contract amendments that do not affect the rates and for the rate changes permitted as specified in 42 C.F.R. §§ 438.4(c) or 438.7(c)(3), CMS does not require a rate amendment from the state. However, if the contract amendment revised 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 C.F.R. § 438.4.

d. New or revised rate certifications are not required for limited payment changes:

i. If the actuary certified rates per rate cell (and not rate ranges), the state may increase or decrease the most recently certified actuarially sound capitation rates per rate cell, as required in 42 C.F.R. §§ 438.7(c) and 438.4(c)(4), up to 1.5 percent during the rating period, in accordance with 42 C.F.R. § 438.7(c)(3).[12]

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[10] For state that implement capitation rate adjustments that result in an increase or decrease of more than 1.5 percent from the most recently certified capitation rates for any rate cell, states will need to submit a rate amendment and contract amendment. The rate amendment must address and account for all difference from the most recently certified rates.

[11] States are permitted to either use the rate range option under 42 C.F.R §§ 438.4(C)(1) or use the *de minimis* rate adjustment under 438.7(c)(3), but states are not permitted to use both mechanisms in combination.

[12] While a rate amendment to the actuarial certification is not required in accordance with 42 C.F.R. § 438.7(c)(3), states must submit a contract amendment to effectuate any rate adjustment as the final capitation rates must be specifically identified in the managed care plan contracts in accordance with 42 C.F.R. § 438.3(c) and are subject to the requirements at 42 C.F.R. § 438.4(b)(1). CMS also expects states to provide documentation that this *de minimis* rate adjustment ensures compliance with 42 C.F.R. § 438.3(c), 438.3(e), 438.4(b)(1) and 438.7(c)(3). States must provide documentation of the percentage change of the rate adjustment per rate cell in comparison to the most recently

Section I. Medicaid Managed Care Rates

1. General Information

ii. If the actuary certified rate ranges for the rate cell(s), the state may increase or decrease the capitation rates per rate cell *with the certified rate range* up to 1 percent during the rating period, in accordance with 42 C.F.R. § 438.4(c)(2).[13]

iii. If the contract and rate certification specify an approved risk adjustment methodology (such as applying risk scores to the capitation rates paid to the managed care plan(s)), the state may apply that specified methodology to increase or decrease payment to the managed care plan(s), in accordance with 42 C.F.R. § 438.7(b)(5)(iii). The Changes to payment in this situation are within the scope of the original, approved rate certification and contract that was reviewed and approved by CMS. The State must provide to CMS the payment terms updated by the application of the risk adjustment methodology consistent with §438.3(c).

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 statues, regulations or approvals. A state must submit a contract amendment and rate amendment to adjust capitation rates to address changes in applicable law or losses of program authority. The rate amendment must take into account the effective date of the loss of program authority. Each state's circumstances may vary and CMS is available to provide technical assistance as needed.

B. Appropriate Documentation	Documentation Reference
i. The certification must clearly indicate whether the actuary is either certifying capitation rates or capitation rate ranges.	• Mercer Rate Certification
ii. States and their actuaries must document all the elements described within their rate certification to provide adequate detail such that CMS	• Mercer Rate Certification

certified actuarially sound capitation rates and an assurance that the state has not previously utilized the flexibility outlined in 42 C.F.R. § 438.7(c)(3) during the applicable rating period.

[13] While a rate amendment to the actuarial certification is not required when the state adjusts the capitation rates within the permissible 1 percent range in accordance with 42 C.F.R. § 438.4(c), states must submit a contract amendment to effectuate any rate adjustment as the final capitation rates must be specifically identified in the managed care plan contracts in accordance with 42 C.F.R. § 438.3(c)(1) and are subject to the requirements at 42 C.F.R. § 438.4(b)(1). CMS also expects states to provide documentation ensuring compliance with 42 C.F.R. § 438.4(b)(1) and (c). States must provide documentation of the percentage change of the rate adjustment per rate cell in comparison to the most recently contracted rates consistent with the certified actuarially sound rate ranges and an assurance that the state has not previously utilized the flexibility outlined in 42 C.F.R. § 438.4(c) during the applicable rating period.

Section I. Medicaid Managed Care Rates	
1. General Information	
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; and c. Methods for analyzing data and developing assumptions and adjustments.	
iii. If the State and its actuary develop and certify capitation rates per rate cell (and not rate ranges), 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.	The rates do not vary by managed care plan. These assumptions are addressed throughout the main sections: • Section 1: General Information • Section 2: Base Data Development • Section 3: Base Rating Adjustments • Section 4: Prospective Rating Adjustments • Section 5: Trends • Section 6: Special Contract Provisions Related to Payment
iv. If the State and its actuary develop and certify capitation rate ranges per rate cell in accordance with 42 C.F.R. § 438.4(c), the rate certification must include the following: a. A statement that both the upper and lower bounds of the rate range are being certified as actuarially sound consistent with the requirements in 42 C.F.R. §§ 438.4 through 438.7.	Mercer is certifying best estimate rates, not rate ranges.

Section I. Medicaid Managed Care Rates

1. General Information

b. A table of the certified rate ranges clearly showing that the upper bound of the rate range does not exceed the lower bound of the rate range multiplied by 1.05 for each rate cell.

c. The data, assumptions, and methodologies used to develop the upper and lower bounds of the rate range. This documentation should include:

   i. Any assumptions (such as trend) for which values are varied in order to develop rate ranges;

   ii. The values of each of the assumptions used to develop the minimum 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 and the maximum of the rate ranges.

d. The state's criteria for paying managed care plans at different points within the rate range, which must comply with the prohibition in 42 C.F.R. § 438.4(c)(1)(v) and other applicable legal authority.[14,15]

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[14] As outlined in the preamble of the 2020 Medicaid and Children's Health Insurance Program (CHIP) Managed Care Rule (85 FR 72764), "we confirm that such criteria could include state negotiations with managed care plans or a competitive bidding process, as long as states document in the rate certification how the negotiations or the competitive bidding process produced different points within the rate range. For example, if specific, documentable components of the capitation rates varied because of state negotiations or a competitive bidding process, the rate certification must document those specific variations, as well as document how those variations produced different points within the rate range, to comply with § 438.4(c)(1)(iv) and (c)(2)(i). We understand that capitation rate development necessarily involves the use of actuarial judgment, such as adjustments to base data, trend projections, etc., and that could be impacted by specific managed care plan considerations (for example, one managed care plan's utilization management policies are more aggressive versus another managed care plan's narrow networks); under this final rule, states must document such criteria as part of the rate certification to comply with § 438.4(c)(1)(iv) and (c)(2)(i)."

[15] When the state submits its rate certification for rate ranges to CMS for review, in accordance with 42 C.F.R. § 438.4(c)(v), the state must also provide an assurance that the State does not use as a criterion for paying managed care plans at different points within the rate range any of the following: (1) the willingness or agreement of the MCOs, PIHPs, or PAHPs or their network providers to enter into, or adhere to, IGT agreements; or (B) The amount of funding the MCOs, PIHPs, or PAHPs or their network providers provide through IGT agreements. In addition, other applicable law concerning the Medicaid program or use of federal grants apply even if not specifically cited in § 438.4(c).

Section I. Medicaid Managed Care Rates	
1. General Information	
e. The information related to rate range development must be included either in the relevant sections of the rate certification or in a separate section related 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 rate certification index must identify where the information and data are described.	
v. 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., a rate amendment that adds a new benefit for part of the year), inapplicable sections of guidance must be included and marked as “Not Applicable” in the index. CMS requires that the rate certification include an index and this index should also follow the structure of this guidance.	N/A
vi. The rate certification must include an assurance that any proposed differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations comply with 42 C.F.R. § 438.4(b)(1), including that any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations are based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations, and that these differences do not vary with the rate of FFP associated with the covered populations in a manner that increases federal costs. States and their actuaries are	• Mercer Rate Certification — Certification of Rates

Section I. Medicaid Managed Care Rates	
1. General Information	
reminded that 42 C.F.R. § 438.4(b)(6) requires the actuary to certify compliance with the rate development requirements in 42 C.F.R. Part 438, including compliance with these requirements related to differences in rates and rate development for different covered populations. CMS may require a state to provide written documentation and justification that any differences in the assumptions, methodologies, or facts used to develop capitation rates for covered populations or contracts represent actual cost assumptions based on the characteristics and mix of covered services or the covered populations. The state must have documentation to provide to CMS upon request, which may include the following information: a. A description of each assumption, methodology, or factor used to develop capitation rates that varies by the rate of FFP associated with all covered populations. b. A justification of how each difference in the assumptions, methodologies, or factors used to develop capitation rates for the covered population represents actual cost differences based on the characteristics and mix of the covered services or the covered populations. c. The financial impact on federal costs of the differences in each of the assumptions, methodologies, or factors used to develop capitation rates for covered populations that varies by the rate of FFP associate with all covered populations.	
vii. 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	• Mercer Rate Certification — Dental Capitation Rates

Section I. Medicaid Managed Care Rates	
1. General Information	
of the costs subject to the different FMAP must be separately shown as part of the rate certification to the extent possible.	
viii. 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. For rate certifications that revise or amend previously certified rates for a rating period, this should be comparison to the latest certified rates for the rating period or to the extent there has been a *de minimis* change to the rates under 42 C.F.R. § 438.7(c)(3), this should be comparison to the rates after the *de minimis* change. 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. c. A description of whether the state adjusted the actuarially sound capitation rates in the previous rating period by a *de minimis* amount using the authority in 42 C.F.R. § 438.7(c)(3).	• Mercer Rate Certification — Rate Change Summary
ix. 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	N/A

Section I. Medicaid Managed Care Rates	
1. General Information	
certification cannot account for changes that are anticipated to be made to the rates.	
x. States and actuaries must document in their rate certification the approach to address the impact of the COVID-19 public health emergency to ensure the rates are actuarially sound in accordance with 42 C.F.R. § 438.4. This must include the following: a. A description of state specific, and other applicable national or regional data that is available and applicable for determining how to address the COVID-19 public health emergency in rate setting. b. A description of how the capitation rates account for the direct and indirect impacts of the COVID-19 public health emergency including but not limited to enrollment changes, new treatments and vaccines, deferred care, expanded coverage of telehealth, etc. c. A description of any risk mitigation strategies being utilized, how the strategies in place compare to the strategies (if any) utilized in the prior rating period, and explanation for any changes.	• Mercer Rate Certification — Trend Adjustments

Section I. Medicaid Managed Care Rates	
2. Data	
A. Rate Development Standards	
i. In accordance with 42 C.F.R. § 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 managed care plan(s) to the state's actuary developing the capitation rates for at least the three most recent and complete years prior to the rating period.	

Section I. Medicaid Managed Care Rates	
2. Data	
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 C.F.R. § 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 describe the corrective action plan for the state to come into compliance with base data standards per 42 C.F.R. § 438.5(c) no later than two years after the last day of the rating period for which the deficiency is identified.	
B. Appropriate Documentation	**Documentation Reference**
i. In accordance with 42 C.F.R. § 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 requested base data was not provided by the state.	• Mercer Rate Certification — Base Data
ii. The rate certification, as supported by the assurances from the state, must thoroughly describe the data used to develop the capitation rates, including:	

Section I. Medicaid Managed Care Rates	
2. Data	
a. A description of the data, including:	
i. The types of data used, which may include, but is not limited to: FFS claims data; managed care encounter data; managed care plan financial data; information from program integrity audits; or other Medicaid program data;	• Mercer Rate Certification — Base Data
ii. The age or time periods of all data used;	• Mercer Rate Certification — Base Data
iii. The sources of all data used (e.g., State Medicaid Agency; other state agencies; managed care plan(s); or other third parties); and	• Mercer Rate Certification — Base Data
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 plan(s) or provider(s); or, if data is not received from the subcapitated plan(s) or provider(s), a description of how the historical costs related to subcapitated arrangements were developed or verified.	N/A
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; managed care plan(s); external quality review organizations; financial auditors; etc.) to validate the data, including: A. Completeness of the data; B. Accuracy of the data; and	• Mercer Rate Certification — Base Data — Non-Claims and Financial Reporting Adjustment — Completion Factors

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C. Consistency of the data across data sources.	
ii. A summary of the actuary's assessment of the data.	• Mercer Rate Certification — Base Data — Certification of Rates
iii. Any concerns that the actuary has regarding the availability or quality of the data.	N/A
c. A description of how the actuary determined what data was appropriate to use for the rating period, including:	
i. If FFS 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.	N/A
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.	N/A
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.	N/A
iii. The rate certification, as supported by the assurances from the state, must thoroughly describe any material adjustments, and the basis for the adjustments, that are made to the data, including but not limited to adjustments for:	

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2. Data	
a. The credibility of the data;	• Mercer Rate Certification — Base Data — Certification of Rates
b. Completion factors;	• Mercer Rate Certification — Completion Factors
c. Errors found in the data;	N/A
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); and	• Mercer Rate Certification — Base Data — Trend Adjustments — Programmatic Changes
e. Exclusions of certain payments or services from the data.	• Mercer Rate Certification — Institutions of Mental Diseases (IMDs)

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3. Projected Benefit Costs and Trends
A. Rate Development Standards[16]
i. Final capitation rates must be based only upon the services allowed in 42 C.F.R. §§ 438.3(c)(1)(ii) and 438.3(e).
ii. In accordance with 42 C.F.R. §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

[16] The state must ensure that it complies with 42 C.F.R. § 438.4(b)(1). Rate development standards and documentation requirements are outlined in Section I, Item. 1 of this guide.

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3. Projected Benefit Costs and Trends	
population or from a similar population and include consideration of other factors that may affect projected benefit cost trends through the rating period.	
iii. If the projected benefit costs include costs for in-lieu-of services defined at 42 C.F.R. §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.iv of this guide.	
iv. 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 C.F.R. §438.2; *see also* section 1903(m)(7) of the Act) for an enrollee age 21 to 64 receiving inpatient treatment in an IMD (as defined in 42 C.F.R. § 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 C.F.R. § 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; and 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	**Documentation Reference**
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 managed care plan(s)).	• Mercer Rate Certification — Dental Capitation Rates, Table 1-1
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 material items in developing the projected benefit costs.	• Mercer Rate Certification

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b. Any material changes to the data, assumptions, and methodologies used to develop projected benefit costs since the last rate certification must be described.	• Mercer Rate Certification – Dental Capitation Rates – Overview – Base Data – Trend Adjustments – Programmatic Changes
c. The amount of recoveries of overpayments to providers and a description of how the state accounted for this in rate development. *See* § 438.608(d).	• Mercer Rate Certification – Base Data – Non-Claims and Financial Reporting Adjustments
iii. The rate certification and supporting documentation must include a section on projected benefit cost trends (i.e., an estimate of the projected change in benefit costs from the historical base data period to the rating period of the rate certification) in accordance with 42 C.F.R. § 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	• Mercer Rate Certification – Trend Adjustments

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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.	• Mercer Rate Certification — Trend Adjustments
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.	• Mercer Rate Certification — Trend Adjustments
iv. Documentation supporting the chosen trend rates and explanation of outlier and negative trends.	N/A
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).	N/A
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.	N/A
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	N/A

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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;[17] ii. Rate cells; and iii. Subsets of benefits within a category of services (e.g., specialty vs. non-specialty drugs).	N/A
d. Any other material adjustments to projected benefit cost trends must be described in accordance with 42 C.F.R. § 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.	N/A
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.	N/A

[17] The state must ensure that it complies with 42 C.F.R. § 438.4(b)(1). Rate development standards and documentation requirements are outlined in Section I, Item. 1 of this guide.

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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 C.F.R. Part 438, subpart K[18] as required by 42 C.F.R. § 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; 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.	N/A
v. For in-lieu-of services defined at 42 C.F.R. § 438.3(e)(2) (i.e., substitutes for State plan services), the following information must be provided and documented: a. The categories of covered services that contain in-lieu-of-services.	N/A

[18] Part 438, subpart K applies the parity standards of the Mental Health Parity and Addiction Equality Act to Medicaid managed care plans consistent with the requirements of section 1932(b) of the Act.

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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 C.F.R. § 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.iv 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.	• Mercer Rate Certification – Base Data - Retroactive Eligibility
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 Medicaid State plan benefits covered by Medicaid managed care;	N/A

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b. Any recoveries of overpayments made to providers by managed care plans in accordance with 42 C.F.R. § 438.608(d); c. Requirements related to payments from managed care plans to any providers or class of providers; d. Requirements or conditions of any applicable waivers; and 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.	N/A
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.	N/A

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4. Special Contract Provisions Related to Payment[19]	
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 managed care plan(s). An incentive arrangement, as defined in 42 C.F.R. § 438.6(a), is any payment mechanism under which a managed care 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 C.F.R. § 438.6(b)(2).	
ii. Appropriate Documentation	**Documentation Reference**
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.	N/A

[19] This rate guidance does not address all requirements for these special contract provisions. States, plans and actuaries are encouraged to review 42 C.F.R. § 438.6 and additional guidance issued by CMS (posted on Medicaid.gov and in the HHS Guidance Portal) for more information and guidance.

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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 managed care plan(s). As defined in 42 C.F.R. § 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 C.F.R. § 438.6(b)(3), the capitation payment(s) minus any portion of the withhold that is not reasonably achievable must be actuarially sound.	

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ii. Appropriate Documentation	**Documentation Reference**
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 measure, or quality-based outcomes, etc.) iv. A description of the total percentage of the 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 managed care plan's financial operating needs accounting for the size and characteristics of the populations covered under the contract, as well as the managed care plan's capital reserves as measured by the risk-based capital level, months of claims reserve, or other appropriate measure of reserves.	N/A

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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.	N/A
C. Risk-Sharing Mechanisms	
i. Rate Development Standards a. In accordance with 42 C.F.R. § 438.6(b), if the state utilizes risk-sharing mechanisms with its managed care plan(s)[20] these arrangements must be documented in the contract(s) and rate certification documents for the rating period prior to the start of the rating period, and must be developed in accordance with § 438.4, the rate development standards in § 438.5, and generally accepted actuarial principles and practices. Risk-sharing mechanisms may not be added or modified after the start of the rating period. b. The rate certification and supporting documentation must describe all risk-sharing mechanisms and indicate if the arrangements affect the rates or the final net payments to the managed care plan(s) under the applicable contract.	
ii. Appropriate Documentation	**Documentation Reference**
a. The rate certification and supporting documentation must include a description of any risk-sharing arrangements. An adequate description of each arrangement 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.	N/A

[20] As used in section 438.6(b)(1), "risk sharing mechanisms" includes any and all mechanisms or arrangements that have the effect of sharing risk between the MCO, PIHP or PAHP and the state on an aggregate level; these include risk mitigation strategies and other arrangements that protect the state or the MCO, PIHP, or PAHP against the risk that the assumptions used in the initial development of capitation rates differ from actual experience. Common risk mitigation strategies include reinsurance, risk corridors, stop-loss limits, a medical loss ratio (MLR) with a remittance, or a risk-based reconciliation payment. 2020 Final Medicaid and Children's Health Insurance Program (CHIP) Managed Care Rule published in the Federal Register on November 13, 2020 (CMS-2408-F) (85 FR 72754, 72774)

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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 also include 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.	• Mercer Rate Certification — Minimum Medical Loss Ratio
c. If the contract has reinsurance requirements, the rate certification and supporting document must also include 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	N/A

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developed, including the data, assumptions and methodology used.	
D. State Directed Payments	
i. Rate Development Standards a. Consistent with 42 C.F.R. § 438.6(c), states may utilize delivery system and provider payment initiatives (i.e., state directed payments), including requiring managed care plans to:[21] 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 using Medicaid State plan approved rates; iv. Adopt a minimum fee schedule for network providers that provide a particular service under the contract using rates other than the Medicaid State plan approved rates; v. Provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract; and vi. Adopt a maximum fee schedule for network providers that provide a particular service under the contract, so long as the managed care plan retains the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract. b. In accordance with 42 C.F.R. § 438.6(c)(2), all state directed payments, except for minimum fee schedules using Medicaid State plan approved rates as defined in 42 C.F.R. § 438.6(a), must receive written prior approval from CMS. Review of rate certification(s) and related contract actions that incorporate these state directed payments cannot be finalized until all necessary written prior approvals are obtained. The state directed payment(s) included in the rate certification must be consistent with the information in the approved preprint and related preprint review	

[21] All state directed payments in Medicaid managed care contracts that are authorized under 42 C.F.R. §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 CMS Informational Bulletin, dated November 2, 2017: http://www.medicaid.gov/federal-policy-guidance/downloads/cib11022017.pdf. Payments permitted under 42 C.F.R. § 438.6(d) must be addressed as noted in section E.

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documents in order for CMS to review and evaluate the state-directed payment and the associated capitation rates and rate certification for approval under §§ 438.4 through 438.7.

c. All contract arrangements that direct MCO's, PIHP's, or PAHP's expenditures must be developed in accordance with 42 C.F.R. § 438.4, the standards specified in § 438.5, and generally accepted actuarial principles and practices.[22]

d. The state's rate certification for the applicable period must address how each state directed payment arrangement under 42 C.F.R. § 438.6(c) is reflected in the payments to the managed care plan from the state in accordance with § 438.7(b)(6) in order to comply with the requirement that the rate certification include a description of any special contract provision related to payment described in § 438.6; in addition, CMS requires the information specified here in order to evaluate compliance of the state-directed payment under § 438.6(c) and the rates as a whole under §§ 438.4 through 438.7. State directed payments can be incorporated into the base capitation rates as an adjustment defined in § 438.5(f) or addressed through a separate payment term. The method by which a state incorporates a state directed payment into a related rate certification(s) will be identified and documented as part of the preprint review process. To comply with 42 C.F.R. §§ 438.7(b)(6) and 438.7(d), when the approved state directed payment preprint and related review documents indicate that the state directed payment will be incorporated through a separate payment term, the state:

   i. Must include documentation related to the payment term in the initial rate certification as outlined in Section I, Item 4.D.ii.a.iii of this guide;

   ii. Must include in the initial rate certification documentation 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

   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 should submit documentation to CMS that incorporates the total amount of the payment into the rate certification's rate cells consistent with the distribution methodology included in the approved state directed payment preprint, 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. Additionally, 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 both the magnitude of and the reason for the change.

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[22] While some state directed payments do not require written approval prior to implementation, all state directed payments must meet the standards in 42 C.F.R. § 438.6(c)(2)(ii)(A) through (F) and be documented in the rate certifications and states' contracts with its managed care plans.

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ii. Appropriate Documentation	Documentation Reference
a. To comply with 42 C.F.R. §§ 438.7(b)(6) and 438.6(c), the rate certification and supporting documentation must include a description of each state directed payment utilized by the state within the applicable Medicaid managed care program(s). The specific description and additional documentation needed depends on which approach the state has used to incorporate the payment into its rate certification. In addition to the information provided in the body of the certification, the state must provide the following information for each state directed payment in the table format outlined below (please include this information for each applicable state directed payment in a separate row):	N/A
i. A brief description of the state directed payment, including the following: A. The type of directed payment arrangement (minimum fee schedule, maximum fee schedule, bundled payment, etc.).	N/A

Control name of the state directed payment[23]	Type of payment (see (i)(A) below)	Brief description (see (i)(B) below)	Is the payment included as a rate adjustment or separate payment term? (see (ii) and (iii) below)
A			
B			
C			

[23] If the state directed payment does not require written approval prior to implementation per 42 C.F.R. § 438.6(c)(2)(ii), and thus does not have a CMS issued control name, the state should provide a name for the state directed payment that clearly describes the arrangement for tracking and organizational purposes.

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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. To comply with 42 C.F.R. §§ 438.7(b)(6) and 438.6(d), if a state directed payment will be incorporated into the rate certification in the base capitation rates as a rate adjustment consistent with the approved preprint and related preprint review documentation, then in addition to the information provided in the body of the certification, the following information must be included in the state's rate certification in the table format (please include this information for each applicable state directed payment in a separate row):

N/A

Control name of the state directed payment[24]	Rate cells affected (see (A) below)	Impact (see (B) below)	Description of the adjustment (see (C) below)	Confirmation the rates are consistent with the preprint (see (D) below)	For maximum fee schedules, provide the information requested in (E) below
A					
B					
C					

A. An indication of each rate cells affected by the state directed payment.

B. A clear reference to the specific exhibit that shows the impact of the state directed payment has on the rates, for each rate cell. Each state directed payment rate adjustment must be separately identified in the exhibit;

[24] See prior footnote.

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the exhibit cannot combine the impacts of state directed payments. C. A description of how the state directed payment is reflected in the certified capitation rates. To the extent an adjustment is applied in rate development to account for the impact of the state directed payment, or changes to the state directed payment 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 state directed payment is consistent with the preprint (including any correspondence between the state and CMS regarding the pre-print) reviewed and approved by CMS, when prior approval is required per 42 C.F.R. § 438.6(c)(2)(ii). To the extent the state directed payment preprint has not been approved by CMS before the actuary certifies the capitation rates, this should be noted in the certification, and the state directed payment under review should still be accounted for in rate development. In this case, the actuary should also provide an indication that the state directed payment is accounted for in the manner consistent with the pre-print that is under CMS review. If the state directed payment preprint has not yet been submitted to CMS for review, the certification should provide a specific timeline for 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 managed care plan(s) paid above the	

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maximum fee schedule and how the actuary determined that it was reasonable to assume that the managed care plan(s) 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 scheduled which allow for managed care plan(s) to pay above the maximum fee schedule during the rating period and how these exemptions were considered in rate development.

iii. If the state directed payment will be incorporated into the initial rate certification as a separate payment term consistent with the approved preprint and related preprint review documentation, then in addition to the information provided in the body of the certification, the following information must be included in the state's rate certification in the following format (please include this information for each applicable state directed payment in a separate row):

N/A

Control name of the state directed payment[25]	Aggregate amount included in the certification (see (A) below)	Statement that the actuary is certifying the separate payment term (see (B) below)	The magnitude to a PMPM basis (see (C) below)	Confirmation the rate development is consistent with the preprint (see (D) below)	Confirmation that the state and actuary will submit required documentation at the end of the rating period (as applicable; see (E) below)
A					
B					

[25] See prior footnote.

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C

A. The aggregate amount of the payment applicable to the rate certification. If the separate payment term directed payment is paid and certified as a part of the capitation rate on a PMPM basis, provide the estimated aggregate amount of the payment.

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. A clear reference to the specific exhibit that shows an estimate of the magnitude of the state directed payment on a PMPM basis for each rate cell (CMS recognizes that this is an estimate for separate payment terms that are incorporated as pools). If the state directed payment, addressed as a separate payment term, is paid and certified as part of the capitation rate on a PMPM basis, provide the amount of the payment on a PMPM basis. Each separate payment term must be separately identified in the exhibit; the exhibit cannot combine the impacts of state directed payments.

D. An indication that the state directed payment is consistent with the pre-print (including correspondence between the state and CMS regarding the pre-print) reviewed and approved by CMS, when prior approval is required 42 C.F.R. § 438.6(c)(2)(ii). To the extent the state directed payment preprint has not been approved by CMS before the actuary certifies the capitation rates, this should be noted in the certification and the state directed payment

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that this is under review should still be accounted for in rate development. In this case, the actuary should also provide an indication that the state directed payment 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 provide a specific timeline for when the preprint will be submitted to CMS. E. A statement that after the rating period is complete, the state will submit to CMS documentation that incorporates the total amount of the state directed payment into the rate certification's rate cells consistent with the distribution methodology included in the approved state directed payment preprint, 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. Note this is only applicable to separate payment terms that are included in the certification as separate pools that are certified in addition to the base PMPM capitation rates.	
b. The rate certification and supporting documentation must confirm that there are no additional directed payments in the program that are not addressed in the certification.	N/A
c. The rate certification and supporting documentation must confirm that there are no requirements regarding the reimbursement rates the managed care plan(s) must pay to any providers unless	N/A

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specifically specified in the certification as a state 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 C.F.R. § 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: [26,27] i. a specific service or benefit provided to a specific enrollee covered under the contract; ii. a provider payment methodology permitted under 42 C.F.R. §§ 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 C.F.R. § 438.6(d). In order to use a transition period, unless permissible in accordance with § 438.6(d)(6),[28] a state must demonstrate that it had pass-through payments for hospitals, physicians, or nursing facilities, as defined in 42 C.F.R. § 438.6(d)(1)(i), in:[29] 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	

[26] States may not require managed care plans to make pass-through payments other than those permitted to network providers that are hospitals, physicians, and nursing facilities in accordance with 42 C.F.R. § 438.6(d)(1).
[27] 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.
[28] Pass-through payments to network providers that are hospitals, nursing facilities, or physicians are allowable for the transition period identified in 42 CFR §438.6(d)(6) for states transitioning services and populations from a FFS delivery system to a managed care delivery system when the state meets the requirements in 42 C.F.R. § 438.6(d)(6).
[29] In accordance with 42 C.F.R. § 438.6(d)(1)(ii), CMS will not approve a retroactive adjustment or amendment, notwithstanding the adjustments to the base amount permitted in 42 C.F.R. § 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.

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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 C.F.R. § 438.6(d).

i. In accordance with 42 C.F.R. § 438.6(d)(3), the aggregate pass-through payments to hospitals may not exceed the lesser of: (1) 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 C.F.R. § 438.6(d)(1)(i).

ii. In accordance with 42 C.F.R. § 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, respectively, identified in the managed care contract(s) and rate certification(s) used to meet the requirement of 42 C.F.R. § 438.6(d)(1)(i).

iii. In accordance with 42 C.F.R. § 438.6(d)(6), for states transitioning services or populations from a FFS delivery system to a managed care delivery system, the aggregate amount of the pass-through payments the State requires the MCO, PIHP or PAHP to make to hospitals, nursing facilities or physicians is less than or equal to the amounts calculated in 42 C.F.R. § 438.6(d)(iii)(A), (B), or (C).[30]

A. In determining the amount of each component for the calculations contained in 42 C.F.R. § 438.6(e)(iii)(A) through (C), the State must use the amounts paid for services during the 12-month period immediately 2 years prior to the first rating period of the transition period.

d. The base amount, as defined in 42 C.F.R. § 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

[30] This requirement is effective for rating periods beginning on or after July 1, 2021 in accordance with the 2020 Final Medicaid and Children's Health Insurance Program (CHIP) Managed Care Rule published in the Federal Register on November 13, 2020 (CMS-2408-F) (85 FR 72754).

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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 C.F.R. § 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 accordance with 42 C.F.R. § 438.6(d)(2)(i)(B).

g. In accordance with 42 C.F.R. § 438.6(d)(2)(iv), states may calculate reasonable estimates of the aggregate differences in 42 C.F.R. § 438.6(d)(2)(i) and (ii) in accordance with the upper payment limit requirements in 42 C.F.R. part 447.

i. If the state chooses to utilize a trend adjustment when calculating reasonable estimates of the aggregate differences in 42 C.F.R. § 438.6(d)(2)(i) and (ii), 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 42 C.F.R. § 438.6(d)(2)(i)(A), (i)(B), (ii)(A) and (ii)(B).

h. Capitation rates may only include pass-through payments to hospitals, physicians and nursing facilities when permitted by 42 C.F.R. § 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 C.F.R. § 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 that allowable amount, the state must amend the rates to comply with Federal requirements. Additionally, the state must include the

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maximum dollar amount of the pass-through payment amounts permitted under 42 C.F.R. § 438.6(d) within its contracts with managed care plan(s).	
ii. Appropriate Documentation	**Documentation Reference**
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. A description of how the pass-through payment will be paid (e.g., an aggregate payment or a PMPM amount where the final aggregate payment varies based on actual enrollment). iii. The amount of the pass-through payment, both in total and on a per member per month basis (if applicable). iv. The program(s) that includes the pass-through payment. v. The providers receiving the pass-through payment. vi. The financing mechanism for the pass-through payment including the following:[31] A. A description of the non-federal share of the pass-through payment, including the source of the non-Federal share and the amount of the non-federal share financing. For example, the funds for the non-federal share may be from state legislative appropriations to the Medicaid agency, intergovernmental transfers (from a state or local	N/A

[31] States must use permissible funding sources that comply with all federal statute and regulations, including section 1903(w) of the Act and 42 CFR Part 433 subpart B, to fund the non-federal share of pass-through payments.

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government entity), provider taxes, or some other mechanism used by the state to provide the non-Federal share. B. For payment funded by intergovernmental transfers, the description should include the following: 1. A complete list of the names of entities transferring funds. 2. The operational nature of the entity (state, county, city, other). 3. The amount transferred by each entity. 4. Clarification on whether the transferring entity has general taxing authority. 5. Clarification on whether the transferring entity received appropriations (identify level of appropriations). 6. Additional information or documentation regarding any written agreements that exist between the state and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement, including a description of any additional written agreements the state is aware may exist with healthcare providers to support and finance the non-federal share of the payment arrangement.	

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C. Identification of any 42 C.F.R. § 438.6(c) state directed payment(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 C.F.R. § 438.6(d)(1)(i)), unless permissible in accordance with § 438.6(d)(6): 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	N/A

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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.	
iv. In accordance with 42 C.F.R. § 438.6(d)(6), for states transitioning services or populations from a FFS delivery system to a managed care delivery system, please provide: A. Confirmation that services will be covered for the first time under a managed care contract and were previously provided in a FFS delivery system prior to the first rating period of the transition period. B. Confirmation that the state made supplemental payments, as defined in 42 C.F.R. § 438.6(a), to hospitals, nursing facilities, or physicians during the 12-month period immediately 2 years prior to the first year of the transition period.	N/A
c. In accordance with 42 C.F.R. § 438.6(d)(4), the certification must document the following information about the base amount for hospital pass-through payments:	N/A

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i. The data, methodologies, and assumptions used to calculate the base amount, including the data, methodologies and assumptions for any reasonable estimate(s) utilized. A. The description must include a summary of any adjustment made to the base data used to calculate amounts in accordance with 42 C.F.R. § 438.6(d)(2)(i)(a), (i)(b), (ii)(a) and (ii)(b), including a rationale and fiscal impact of each adjustment. B. An explanation of any changes to the methodology utilized for the base amount calculation for the previous years' calculations including a rational and fiscal impact of the proposed methodology changes. ii. The aggregate amounts calculated for 42 C.F.R. § 438.6(d)(2)(i)(a), (i)(b), (ii)(a) and (ii)(b). iii. If the state chooses to utilize trend adjustments when calculating the amounts identified in accordance with 42 C.F.R. § 438.6(d)(2)(i)(a), (i)(b), (ii)(a) and (ii)(b), the state must ensure clear documentation, including: A. Explanation of the purpose of the trend adjustment (e.g., cost inflation, utilization, etc.) and justification of why an adjustment is reasonable and appropriate. B. The trend adjustment applied to amounts, as applicable, in accordance with 42 C.F.R. § 438.6(d)(2)(i)(a), (i)(b), (ii)(a) and (ii)(b). C. A description of the data source, assumptions, and methodology used to determine each adjustment. D. The fiscal impact of each trend adjustment.	

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E. 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 C.F.R. 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 accordance with 42 C.F.R. § 438.6(d)(3). v. The amount of any § 438.6(c) state directed payment(s) 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 accordance with 42 C.F.R. § 438.6(d)(2)(i)(B). d. In accordance with 42 C.F.R. § 438.6(d)(6), the certification must document the calculations in 42 C.F.R. § 438.6(d)(iii)(A), (B), or (C) for states transitioning services or populations from a FFS delivery system to a managed care delivery system, including the data, methodologies and assumptions used to develop these calculations.	

Section I. Medicaid Managed Care Rates

5. Projected Non-Benefit Costs

A. Rate Development Standards[32]

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 mental health parity standards in 42 C.F.R. § 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.

B. Appropriate Documentation	Documentation Reference
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 C.F.R. § 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 material items in developing the projected non-benefit costs.	• Mercer Rate Certification — Non-Medical Expense Load

[32] The state must ensure that it complies with 42 C.F.R. § 438.4(b)(1). Rate development standards and documentation requirements are outlined in Section I, Item.1 of this guide.

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5. 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 C.F.R. § 438.7(b)(4), including: i. A description of the data, assumptions, and methodologies used to determine each adjustment. ii. Where in the rate 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; and d. Other operational costs associated with the provision of services identified in § 438.3(c)(1)(ii) to the populations covered under the contract.	• Mercer Rate Certification — Non-Medical Expense Load
iii. Actuaries should disclose historical non-benefit cost data in the certification to the extent this information was provided by the managed care plan(s), and explain how the historical non-benefit cost data was considered in the non-benefit cost assumptions used in the rate development.	• Mercer Rate Certification — Non-Medical Expense Load

Section I. Medicaid Managed Care 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 C.F.R. § 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 C.F.R. § 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.

B. Appropriate Documentation	**Documentation Reference**
i. In accordance with 42 C.F.R. § 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.	The rates do not vary by managed care plan.

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6. Risk Adjustment and Acuity Adjustments	
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 C.F.R. § 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.	N/A
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 C.F.R. § 438.5(g).	N/A
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	N/A

Section I. Medicaid Managed Care Rates	
6. Risk Adjustment and Acuity Adjustments	
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
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

Section II. Medicaid Managed Care Rates with Long-Term Services and Supports	
1. Managed Long-Term Services and Supports	
b. by the long-term care setting that the beneficiary uses (“non-blended”).	
C. Appropriate Documentation	**Documentation Reference**
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 managed care plan(s) 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).	N/A
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.	N/A
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.	N/A

Section III. New Adult Group Capitation Rates	Documentation Reference
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.	N/A
B. For states that have covered the new adult group in Medicaid managed care plan(s) in previous rating periods (i.e., starting in 2014, 2015, 2016, 2017, 2018, 2019, 2020 and/or January through June 2021), 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.	N/A

Section III. New Adult Group Capitation Rates	Documentation Reference
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	

Section III. New Adult Group Capitation Rates	Documentation Reference
2. Projected Benefit Costs	
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.	N/A
b. Any changes in data sources, assumptions, or methodologies used to develop projected benefits costs for capitation rates since the last rate certification.	N/A
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; vi. Other material changes or adjustments to the new adult group projected benefit costs; and vii. Any changes to the benefit plan offered to the new adult group.	N/A

Section III. New Adult Group Capitation Rates	Documentation Reference
2. Projected Benefit Costs	
ii. For states that did not cover the new adult group in previous rating periods: a. Descriptions of any difference of the benefit plan offered to the new adult group population and other covered populations (i.e., the non-new adult group populations).	N/A
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 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; and f. Other material adjustments to the new adult group projected benefit costs.	N/A
B. The rate certification and supporting documentation must describe any other material changes or adjustments to projected benefit costs.	N/A

Section III. New Adult Group Capitation Rates	Documentation Reference
3. Projected Non-Benefit Costs	
A. In addition to the guidance for 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 plan(s) 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; and e. Other material non-benefit costs.	N/A
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; and v. Other material non-benefit costs.	N/A

Section III. New Adult Group Capitation Rates	Documentation Reference
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 C.F.R. § 438.7(d)[33] that states that covered the new adult group in Medicaid managed care plan(s) in previous rating periods provide: i. A comparison to the final certified rates 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.	N/A

Section III. New Adult Group Capitation Rates	Documentation Reference
5. Risk Mitigation Strategies	
A. CMS requests under 42 C.F.R. § 438.7(d) that states describe any risk mitigation strategy that is specific to the new adult group. In accordance with 42 C.F.R. § 438.6(b), if the state utilizes risk-sharing mechanisms with its managed care plan(s)[34] these arrangements must be documented in the contract(s) and rate certification documents for the rating period prior to the start of the rating period, and must be developed in accordance with § 438.4, the rate development standards in § 438.5, and	N/A

[33] 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.

[34] As used in section 438.6(b)(1), "risk sharing mechanisms" includes any and all mechanisms or arrangements that have the effect of sharing risk between the MCO, PIHP or PAHP and the state on an aggregate level; these include risk mitigation strategies and other arrangements that protect the state or the MCO, PIHP, or PAHP against the risk that the assumptions used in the initial development of capitation rates differ from actual experience. Common risk mitigation strategies include reinsurance, risk corridors, stop-loss limits, a medical loss ratio (MLR) with a remittance, or a risk-based reconciliation payment. 2020 Final Medicaid and Children's Health Insurance Program (CHIP) Managed Care Rule published in the Federal Register on November 13, 2020 (CMS-2408-F) (85 FR 72754, 72774)

Section III. New Adult Group Capitation Rates	Documentation Reference
5. Risk Mitigation Strategies	
generally accepted actuarial principles and practices. Risk-sharing mechanisms may not be added or modified after the start of the rating period.	
B. For states that covered the new adult group in Medicaid managed care plan(s) 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.	N/A