Office of State Procurement
PROACT Contract Certification of Approval

This certificate serves as confirmation that the Office of State Procurement has reviewed and approved the contract referenced below.

Reference Number: 2000506234 (1)
Vendor: DentaQuest USA Insurance Company, Inc.
Description: Dental amd 1 - adds Att. C Performance Measures and Att. D Rate Cert
Approved By: Pamela Rice
Approval Date: 3/02/2021

Your amendment that was submitted to OSP has been approved.

Rev 2019-12

AMENDMENT TO
AGREEMENT BETWEEN STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

Amendment #: 1
LAGOV#: 2000506234
LDH #:

MVA
(Regional/ Program/ Facility)

Medical Vendor Administration
Bureau of Health Services Financing

Original Contract Amount: $355,700,072.00
Original Contract Begin Date: 01-01-2021
Original Contract End Date: 12-31-2023
RFP Number: 3000013043

AND

DentaQuest USA Insurance Company, Inc.
Contractor Name

AMENDMENT PROVISIONS

Change Contract From: Current Maximum Amount: $355,700,072.00 Current Contract Term: ~~1/1/2020~~ 1/1/2021 - 12/31/2023

Attachment B - Statement of Work
Attachment C - Placeholder
Attachment D - Rate Certification Placeholder

DBPM Initials SJP 2/1/21

Tara A LeBlanc Digitally signed by Tara A LeBlanc Date: 2021.02.05 09:43:30 -06'00'

Medicaid Director Initials

Change Contract To: If Changed, Maximum Amount: If Changed, Contract Term:

Attachment B1 - Changes to Statement of Work
Attachment C - Dental Benefit Plan Performance Measurement Goals
Attachment D - Rate Certification

Justifications For Amendment:

This amendment will add Attachment C - Dental Benefit Plan Performance Measurement Goals and Attachment D - Rate Certification.

Attachment B1 revises the Statement of Work, including provisions related to provider credentialing, claims reprocessing, medical loss ratio, and conflict of interest.

DBPM Initials SJP 2/1/21 Medicaid Director Initials Tara A LeBlanc Digitally signed by Tara A LeBlanc Date: 2021.02.05 06:28:48 -06'00'

This Amendment Becomes Effective: 01-01-2021

This amendment contains or has attached hereto all revised terms and conditions agreed upon by contracting parties.

IN WITNESS THEREOF, this amendment is signed and entered into on the date indicated below.

CONTRACTOR

DentaQuest USA Insurance Company, Inc.

CONTRACTOR SIGNATURE [signature] DATE 1/12/2021

PRINT NAME: Steven Pollock

CONTRACTOR TITLE: President and CEO

STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

Secretary, Louisiana Department of Health or Designee

SIGNATURE Tara A LeBlanc Digitally signed by Tara A LeBlanc Date: 2021.01.19 11:24:05 -06'00' DATE

NAME: Tara LeBlanc

TITLE: Interim Medicaid Executive Director

OFFICE: Louisiana Department of Health

PROGRAM SIGNATURE DATE

NAME

DBPM Contract Amendment #1
Attachment B-1

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
1	Attachment B Statement of Work	2.11.2.1.3 The DBPM is encouraged to include an enrollee advocate representative on the QAPI Committee.	2.11.2.1.3 The DBPM ~~is encouraged to~~ shall include an enrollee advocate representative on the QAPI Committee.	This revision requires the inclusion of an enrollee advocate to consider the enrollee perspective on quality improvement activities.
2	Attachment B Statement of Work	2.12.1.1 The DBPM, its subcontractors and providers shall comply with all state and federal laws and regulations relating to fraud, abuse, and waste in the Medicaid and CHIP programs, including but not limited to 42 CFR §438.1-438.812; La. R.S. 46:437.1-437.14; 42 CFR §455.12 – 455.23; LAC 50:I.4101-4235; and Sections 1128, 1156, and 1902(a)(68) of the Social Security Act.	2.12.1.1 The DBPM, its subcontractors and providers shall comply with all state and federal laws and regulations relating to fraud, abuse, and waste in the Medicaid and CHIP programs, including but not limited to 42 CFR §438.1-438.608, 42 CFR §438.611-438.812; La. R.S. 46:437.1-437.14; 42 CFR §455.12 – 455.23; LAC 50:I.4101-4235; and Sections 1128, 1156, and 1902(a)(68) of the Social Security Act. Compliance with 42 CFR §438.610 is also required until the State notifies the DBPM that it has implemented its own screening of DBPM-only providers and has notified the DBPM that it has assumed this function.	The DBPMs will no longer perform their own ownership disclosure collection and screening once LDH will be doing that same collection and screening for DBPM-only providers. This eliminates duplicative screening and decrease provider abrasion by eliminating an onerous part of the DBPM credentialing process, while not introducing risk for the state. LDH anticipates to begin screening on 3/1/2020.
3	Attachment B Statement of Work	2.12.1.8 The DBPM, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements on disclosure reporting per 42 CFR §455.104 and 42 CFR §438.610. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of the Contract shall submit routine disclosures in accordance with timeframes specified in federal regulations and Louisiana Medicaid Policies and Procedures, including at the time of initial contracting, contract renewal, within thirty-five (35) calendar days of any change to any of the information on the disclosure form, at least once annually, and at any time upon request.	2.12.1.8 Until the State implements its own screening of DBPM-only providers and has notified the DBPM that it has assumed this function, t~~T~~he DBPM, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements on disclosure reporting per 42 CFR §455.104 and 42 CFR §438.610. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of the Contract shall submit routine disclosures in accordance with timeframes specified in federal regulations and Louisiana Medicaid Policies and Procedures, including at the time of initial contracting, contract renewal, within thirty-five (35) calendar days of any change to any of the information on the	The DBPMs will no longer perform their own ownership disclosure collection and screening once LDH will be doing that same collection and screening for DBPM-only providers. This eliminates duplicative screening and decrease provider abrasion by eliminating an onerous part of the DBPM credentialing process, while not introducing risk for the state. LDH anticipates to begin screening on 3/1/2020.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			disclosure form, at least once annually, and at any time upon request.	
4	Attachment B Statement of Work	2.12.3.5 The DBPM and its subcontractors shall comply with all applicable provisions of 42 CFR §438. 608 and 438.610 pertaining to debarment and/or suspension including written disclosure to LDH of any prohibited affiliation. The DBPM and its subcontractors shall screen all employees, contractors, and network providers to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or any federal health care programs. To help make this determination, the DBPM shall conduct screenings to comply with the requirements set forth at 42 CFR §455.436.	2.12.3.5 The DBPM and its subcontractors shall comply with all applicable provisions of 42 CFR §438.608 and 438.610 pertaining to debarment and/or suspension including written disclosure to LDH of any prohibited affiliation. The DBPM and its subcontractors shall screen all employees, contractors, and network providers to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or any federal health care programs. To help make this determination, the DBPM shall conduct screenings to comply with the requirements set forth at 42 CFR §455.436. This section does not require ownership disclosure collection and screening once the State has implemented its own DBPM-only provider screening and has notified the DBPM that it has assumed this function.	The DBPMs will no longer perform their own ownership disclosure collection and screening once LDH will be doing that same collection and screening for DBPM-only providers. This eliminates duplicative screening and decrease provider abrasion by eliminating an onerous part of the DBPM credentialing process, while not introducing risk for the state. LDH anticipates to begin screening on 3/1/2020.
5	Attachment B Statement of Work	[end of section]	2.14.2.2.2 If the DBPM or LDH or its subcontractors discover errors made by the DBPM when a claim was adjudicated, the DBPM shall make corrections and reprocess the claim within thirty (30) calendar days of discovery, or if circumstances exist that prevent the DBPM from meeting this time frame, a specified date shall be approved by LDH. The DBPM shall pay providers interest at twelve percent (12%) per annum, calculated daily for the full period in which a payable clean claim remains unpaid beyond either the thirty (30) day claims reprocessing deadline or the specified deadline approved by LDH, whichever is later. The DBPM shall automatically recycle all impacted claims for all providers and shall not require the provider to resubmit the impacted claims.	This new provision adds requirements for reprocessing claims that are denied or paid inappropriately as a result of the DBPM's errors and requiring the payment of associated interest providers when applicable.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
6	Attachment B Statement of Work	3.6.5 Table of Monetary Penalties [new penalty]	Number: 23 Requirement: Failure to comply with conflict of interest requirements specified in the Contract. Monetary penalty: $10,000.00 per occurrence plus an additional $5,000.00 per calendar day after notification by LDH that the DBPM remains in violation.	This addition ties a specific monetary penalty to the violation of the conflict of interest prohibition (sections 1.4.1, 6.43).
7	Attachment B Statement of Work	4.5 Medical Loss Ratio 4.5.1 In accordance with the DBPM Financial Reporting Guide published by LDH, which can be found in the Procurement Library, the DBPM shall provide an annual Medical Loss Ratio (MLR) report following the end of the MLR reporting year, which shall be a calendar year. 4.5.2 An MLR shall be reported in the aggregate, including all dental services covered under the Contract. 4.5.3 If the aggregate MLR (cost for dental benefits and services and specified quality expenditures) is less than eighty-five percent (85%), the DBPM shall refund LDH the difference. Any unpaid balances after the refund is due shall be subject to interest at the current Federal Reserve Board lending rate or ten percent (10%) annually, whichever is higher. 4.5.4 Neither the minimum MLR standard eighty-five percent (85%) nor the refund applicable to the aggregate MLR shall apply to distinct MLRs reported.	4.5 Medical Loss Ratio 4.5.1 In accordance with the DBPM Financial Reporting Guide published by LDH, ~~which can be found in the Procurement Library,~~ the DBPM shall provide an annual Medical Loss Ratio (MLR) report following the end of the MLR reporting year, which shall be a calendar year, except in circumstances in which the reporting period must be revised to align to a CMS-approved capitation rating period. 4.5.2 An MLR shall be reported in the aggregate, including all dental services covered under the Contract, unless the department requires separate reporting and separate MLR calculation for specific populations. 4.5.2.1 In accordance with Section 4001 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, enacted October 24, 2018, a separate MLR shall be reported and calculated for the Expansion population. 4.5.3 If the ~~aggregate~~ MLR (cost for dental benefits and services and specified quality expenditures) is less than eighty-five percent (85%), the DBPM shall refund LDH the difference. Any unpaid balances after the refund is due shall be subject to interest at the current Federal Reserve Board lending rate or ten percent (10%) annually, whichever is higher.	Under a provision of the SUPPORT Act, Louisiana would be entitled a larger share of any MLR rebated received from a contracted Managed Care Entity. CMS has allowed for the Federal share of MLR remittance attributable to Expansion populations to be calculated at regular Federal Medical Assistance Percentage (FMAP), as opposed to the enhanced Expansion FMAP for periods within Federal Fiscal Years 2020 – 2023.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			~~4.5.4 Neither the minimum MLR standard eighty-five percent (85%) nor the refund applicable to the aggregate MLR shall apply to distinct MLRs reported.~~	
8	Attachment C Dental Benefit Plan Performance Measurement Goals	Attachment C placeholder	New attachment outlining performance measurement goals.	LDH established benchmarks for clinical performance measures utilizing statewide data of the Medicaid population from previous year(s) with the expectation that performance improves by a certain percentage toward the benchmarks. If a DBPM is deficient with a performance measures, LDH may assess monetary penalties to obtain the level of performance required for successful operation of the Louisiana Medicaid program.
9	Attachment D Rate Certification	Attachment D placeholder	New rate certification effective January 1, 2021 – December 31, 2021.	

Dental Benefit Plan Performance Measurement Goals

Performance Measurement Goals are to be achieved by the end of each reporting period. Each measurement year shall be compared to the prior year.

Performance Measure #1

Dental Benefit Plan Clinical Performance CMS-416 Line 12b	Reporting Period	Baseline % 2019	FFY 2020	FFY 2021	FFY 2022
Increase the percentage of EPSDT enrollees (enrolled for at least 90 consecutive days), age 1-20, receiving at least 1 preventative dental service	FFY	49.6%	52.1%	54.5%	57.0%
Reporting Deadline	-	-	03/31/2021	03/31/2022	03/31/2023

FFY= Federal Fiscal Year (October 1 – September ~~31~~ 30)

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DBPM Initials SJP 2/1/21 Medicaid Director Initials

Performance Measure #2

Dental Benefit Plan Clinical Performance HEDIS ADV	Reporting Period	Baseline % 2019	CY 2020	CY 2021	CY 2022
Increase the percentage of EPSDT enrollees (enrolled for at least 45 consecutive days), age 2-20, receiving at least 1 dental visit	CY	58.75%	61.25%	63.75%	66.25%
Reporting Deadline	-	-	06/30/2021	06/30/2022	06/30/2023

CY= Calendar Year (January 1 – December 31)

MERCER

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Mr. Daniel Cocran
Chief Financial Officer
Louisiana Department of Health
628 North 4th Street
Baton Rouge, LA 70821 0629

December 21, 2020

Subject: Louisiana Medicaid Dental Benefit Program Capitation Rate Certification for the Period January 1, 2021 through December 31, 2021

Dear Mr. Cocran:

In partnership with the State of Louisiana (State), Mercer Government Human Services Consulting (Mercer) 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, 2021 through December 31, 2021.

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 a range 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.

Although the utilization of dental services was significantly impacted starting in March 2020, the ongoing impact to dental utilization in rating year 2021 (RY21) is somewhat uncertain. At this time, explicit adjustments related to the COVID-19 pandemic were not considered in RY21 base capitation rate development. Mercer and the State will collect the dental information in response to the pandemic and continue to monitor the ongoing effects of the pandemic on the service delivery environment. As more information emerges, the impact on the managed care program will be evaluated and may result in a

[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.

capitation rate update, which may result in contract changes and/or further capitation rate considerations.

Dental Capitation Rates

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

Tale 1-1: Dental Capitation Rates

January 1, 2021 through December 31, 2021	
Rate Cell Description	**Monthly Capitation Rate Per Member**
LaCHIP Affordable Plan	$28.08
Medicaid Child/CHIP	$23.14
Medicaid Adult	$1.84
Medicaid Expansion Child	$22.30
Medicaid Expansion Adult	$1.11

Table 1-2 compares the new capitation rates to those established for the prior period (July 1, 2020 through December 31, 2020).

Table 1-2: Rate Change Summary

Rate Cell	Jul 2020–Dec 2020 Rates	Jan 2021–Dec 2021 Rates	% Change
	[A]	[B]	[C] = [B]/[A] - 1
LaCHIP Affordable Plan	$27.22	$28.08	3.20%
Medicaid Child/CHIP	$22.82	$23.14	1.40%
Medicaid Adult	$1.85	$1.84	-0.50%
Medicaid Expansion Child	$21.96	$22.30	1.50%
Medicaid Expansion Adult	$1.10	$1.11	0.90%

For the capitation rates for the contract period January 1, 2021 through December 31, 2021, the main drivers of the rate change from the prior period were as follows:

- Negative impact of including intermediate care facilities for individuals with intellectual disabilities (ICF/IID) population

- Increased impact of full Medicaid pricing (FMP)

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 2020-2021 Medicaid Managed Care Rate Development Guide (RDG) published in July 2020. 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 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, 2021 through December 31, 2021, Mercer relied on Louisiana Medicaid eligibility and enrollment data and managed care encounter data from state fiscal year (SFY) 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 (IMDs)

The base data was adjusted to remove member months (MMs) and dental claims associated with enrollees aged 21–64 who stayed in an IMD for more than 15 days. The adjustment reduced the Medicaid Adult base MMs from 3,604,480 to 3,604,238 for SFY 2019. The Medicaid Expansion Adult base MMs for SFY 2019 decreased from 5,437,097 to 5,436,941 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 Adjustment

Rate Cell	Base MMs (Includes IMD)	IMD Adjusted MMs	% Change
	[A]	[B]	[C] = [B]/[A] - 1
Medicaid Adult SFY 2019	3,604,480	3,604,238	-0.10%
Medicaid Expansion Adult SFY 2019	5,437,097	5,436,941	0.00%

Under-Reporting Adjustment

The under-reporting 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 by Child versus Adult. 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 1.87% and 4.95% for Child and Adult groups, respectively. The total increase to the overall SFY 2019 base PMPM was 2.03%.

Table 3-2: Under-Reporting

Rate Cell	Base PMPM	UR Adjusted PMPM	% Change
	[A]	[B]	[C] = [B]/[A] - 1
Medicaid Child Groups SFY 2019	$14.42	$14.69	1.87%
Medicaid Adult Groups SFY 2019	$0.82	$0.86	4.95%
Total SFY 2019	**$7.75**	**$7.91**	**2.03%**

Completion Factors

The encounter data included claims for dates of service from July 1, 2018 through June 30, 2019, and payments through December 31, 2019. Mercer estimated and adjusted for the remaining liability

associated with incurred but not reported claims for SFY 2019. The overall adjustment was 0.07% for SFY 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.

Trend Adjustments

Trend is an estimate of the change in the overall cost of providing health care benefits 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 trend adjustments, Mercer primarily considered historical experience based on Louisiana encounter data. Mercer also reviewed dental trend benchmarks in other state Medicaid programs and commercial dental managed care programs prior to the COVID-19 pandemic. Specifically, Mercer evaluated the trends based on program experience through July 2019. To support this review, Mercer used a proprietary model that regressed unit cost, utilization and PMPMs by rate cell using up to three years of historical encounter data. Mercer evaluated trend patterns to examine and project utilization and unit cost trends for the rate period. In general, observed downward trend for Medicaid Expansion Adult population and upward trend for the rest of the populations. Total PMPM annual trend applied to LaCHIP Affordable Plan is 0.25%, Medicaid Child/CHIP is 1.25% and Medicaid Adult is 0.50%. Total PMPM annual trend applied to Medicaid Expansion Child is 1.25% and Medicaid Expansion Adult is -2.00%. Table 4 below shows the annual PMPM trends.

Table 4: Trend

Rate Cell	Total PMPM Annual Trend
LaCHIP Affordable Plan	0.25%
Medicaid Child/CHIP	1.25%
Medicaid Adult	0.50%
Medicaid Expansion Child	1.25%
Medicaid Expansion Adult	-2.00%

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.

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 (EPSDT) Dental Program Fee Schedule Update

Effective July 1, 2019, LDH released an updated 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 between the base period and the contract period using the fee schedule effective July 1, 2019.

Table 5-1: 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
SFY 2019	LaCHIP Affordable Plan	$129,753	$29,336	22.61%	4.66%
SFY 2019	Medicaid Child/CHIP	$25,854,359	$5,884,843	22.76%	4.57%
SFY 2019	Medicaid Adult	$0	$0	0.00%	0.00%
SFY 2019	Medicaid Expansion Child	$2,773,266	$607,575	21.91%	9.26%
SFY 2019	Medicaid Expansion Adult	$0	$0	0.00%	0.00%
Total		**$28,757,378**	**$6,521,754**	**22.68%**	**4.55%**

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

ICF/IID Population

Effective January 1, 2021, the Louisiana Medicaid DBP will begin to cover 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 5-2: ICF/IID Populations Impact

Time Period	Rate Cell	Historical PMPM	Adjusted PMPM	Impact As %
SFY 2019	LaCHIP Affordable Plan	$17.56	$17.56	0.00%
SFY 2019	Medicaid Child/CHIP	$14.40	$14.39	-0.03%
SFY 2019	Medicaid Adult	$1.05	$1.04	-1.48%
SFY 2019	Medicaid Expansion Child	$13.43	$13.43	0.00%
SFY 2019	Medicaid Expansion Adult	$0.66	$0.66	0.00%
Total		**$7.75**	**$7.72**	**-0.30%**

FMP

Effective January 1, 2020, LDH implemented a program change to increase payments for dental providers. This change required the use of an 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 (PPO) 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 5-3 shows the impact of FMP on the historical cost.

Table 5-3: Fee Schedule Changes

Time Period	Rate Cell	Projected PMPM	FMP PMPM	Impact As %
SFY 2019	LaCHIP Affordable Plan	$18.85	$6.26	33.22%
SFY 2019	Medicaid Child/CHIP	$15.83	$4.83	30.53%
SFY 2019	Medicaid Adult	$1.10	$0.56	50.42%
SFY 2019	Medicaid Expansion Child	$15.43	$4.46	28.89%
SFY 2019	Medicaid Expansion Adult	$0.66	$0.34	51.05%
Total		**$8.32**	**$2.62**	**31.46%**

Special Contract Provision Related to payment

Minimum Medical Loss Ratio (MLR)

In accordance with the DBP contractor Financial Reporting Guide published by LDH, the DBP contractor shall provide an 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 2021 through December 2021 contract period. In total, the overall non-medical expense load applied to the rates is 13.00%.

Federal Health Insurance Provider Fee (HIPF)

Louisiana recognizes expenses related to the 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, 2021 through December 31, 2021.

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, 2021 through December 31, 2021, 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 Han Lu at +1 404 442 3167.

Sincerely,

Han Lu, ASA, MAAA
Associate

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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

Louisiana Medicaid Dental Benefit Program
January 1,2021 through December 31, 2021

Table 1

			Base Data Adjustments		
	[A]	[B]	[C]	[D]	[E]
Rate Cell Description	SFY 2019 MMs	SFY 2019 PMPM	Under-reporting	IBNR	Adjusted Base PMPM
LaCHIP Affordable Plan	35,879	$ 17.56	1.87%	0.05%	$ 17.90
Medicaid Child/CHIP	8,946,319	$ 14.40	1.87%	0.06%	$ 14.68
Medicaid Adult	3,604,238	$ 1.05	4.95%	0.18%	$ 1.11
Medicaid Expansion Child	488,477	$ 13.43	1.87%	0.06%	$ 13.69
Medicaid Expansion Adult	$ 5,436,941.00	$ 0.66	4.95%	0.18%	$ 0.70
Total	18,511,854	$ 7.75	2.03%	0.07%	$ 7.91

Notes:

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

Table 2

	Projected Benefit							
	[A]	[B]	[C]	[D]	[E]	[F]	[G]	[H]
Rate Cell Description	SFY 2019 PMPM	Annual Trend	Trend Months	Trended PMPM	7/1/19 Fee Schedule Change	ICF/IID Adjustment	FMP Add-on	Program Changes Adjusted PMPM
LaCHIP Affordable Plan	$ 17.90	0.25%	30	$ 18.01	4.66%	0.00%	$ 6.26	$ 25.12
Medicaid Child/CHIP	$ 14.68	1.25%	30	$ 15.14	4.57%	-0.03%	$ 4.83	$ 20.66
Medicaid Adult	$ 1.11	0.50%	30	$ 1.12	0.00%	-1.48%	$ 0.56	$ 1.66
Medicaid Expansion Child	$ 13.69	1.25%	30	$ 14.12	9.26%	0.00%	$ 4.46	$ 19.89
Medicaid Expansion Adult	$ 0.70	-2.00%	30	$ 0.66	0.00%	0.00%	$ 0.34	$ 1.00
Total[1]	**$ 7.91**	**0.27%**	**30**	**$ 7.96**	**4.52%**	**-0.06%**	**$ 2.62**	**$ 10.94**

	Retention Load					
	[I]	[J]	[K]	[L]	[M]	[N]
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%	$ 6.41	$ 28.08
Medicaid Child/CHIP	9.00%	2.00%	2.25%	13.00%	$ 4.94	$ 23.14
Medicaid Adult	9.00%	2.00%	2.25%	13.00%	$ 0.57	$ 1.84
Medicaid Expansion Child	9.00%	2.00%	2.25%	13.00%	$ 4.56	$ 22.30
Medicaid Expansion Adult	9.00%	2.00%	2.25%	13.00%	$ 0.35	$ 1.11
Total[1]	**9.00%**	**2.00%**	**2.25%**	**13.00%**	**$ 2.68**	**$ 12.25**

Notes:
[A] = Table 1 [E]
[D] = [A] x (1 + [B])^([C] / 12)
[H] = [D] x (1 + [E]) x (1+[F])+ [G]
[L] = 1 - (1 - ([H] + [I])) x (1 - [J])
[M] = [G] / (1 - [K])
[N] = ([H] - [G]) / (1 - [K]) + [M]
1.Adjusted PMPM is based on constant enrollment mix (January 2021–December 2021 projected enrollment).

Attachment D

MERCER

July 2020–June 2021 Medicaid Managed Care Rate Development Guide

Louisiana — January 1, 2021–December 31, 2021

Section I. Medicaid Managed Care Rates

- **General Information**

A. Rate Development Standards

i. Rate certifications must be done for a 12-month rating period.[1] CMS will consider a time period other than 12 months to address unusual circumstance. For example, CMS would approve a time period other than 12 months for the following reasons:

   a. when the state is trying to align program rating periods, which may require a rating period longer than one year (but less than two years); or

   b. when the state needs to make an amendment to the contract and the rates for an already approved rating period need to be adjusted accordingly.

ii. In accordance with 42 CFR §438.4, 438.5, 438.6, and 438.7, an acceptable rate certification submission, as supported by the assurances from the state, includes the following items and information:

   a. a letter from the certifying actuary, who meets the requirements for an actuary in 42 CFR §438.2, who certifies that the final capitation rates meet the standards in 42 CFR §438.3(c), 438.3(e), 438.4, 438.5, 438.6, and 438.7.

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

Attachment D

Section I. Medicaid Managed Care Rates

• General Information

b. the final and certified capitation rates for all rate cells in accordance with 42 CFR §438.4(b)(4), and all regions (as applicable). [2] Additionally, the contract must specify the final capitation rate(s) in accordance with 42 CFR §438.3(c)(1)(i).

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

   i. a summary of the specific state Medicaid managed care programs covered by the rate certification, including, but not limited to:

      A. the types and numbers of managed care plans included in the rate development (e.g., type means managed care organizations, prepaid inpatient health plans, or prepaid ambulatory health plans).

      B. a general description or list of the benefits that are required to be provided by the managed care plan or plans (e.g., types of medical services, behavioral health or mental health services, long-term care services, etc.), particularly noting any benefits that are carved out of the managed care program or that are new to the managed care program in that rating period covered.

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

   ii. the rating period covered by the rate certification.

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

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

   v. a summary of the special contract provisions related to payment that, per 42 CFR §438.6, are included within rate development (e.g. risk-sharing mechanisms, incentive arrangements, withhold arrangements, state-directed delivery system reform and

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

Section I. Medicaid Managed Care Rates

• General Information

provider payment initiatives,[3] pass-through payments, and payments to MCOs and PIHPs for enrollees that are a patient in an Institution of Mental Disease (IMD)).

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

A. describe the rationale for the adjustment; and

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

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

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

v. The effective dates of changes to the Medicaid managed care program (including eligibility, benefits, payment rate requirements, incentive programs, and program initiatives) must be consistent with the assumptions used to develop the capitation rates.

vi. Capitation rates must be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio, as calculated under 42 CFR §438.8, of at least 85 percent for the rate year. The capitation rates may be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard greater than 85 percent, as calculated under 42 CFR §438.8, as long as the capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs. Under §438.8(j), the state may choose to impose remittance provisions related to this medical loss ratio. The terms and conditions of any remittance must

[3] 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 CFR §438.6(c) and receive prior approval before implementation. In order to ensure that States can have these directed payment arrangements reviewed and approved prior to developing rates, CMS has a separate process for submitting payment arrangements under 42 CFR §438.6(c).

Section I. Medicaid Managed Care Rates

• General Information

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.[4]

vii. As part of CMS's determination of whether or not the rate certification submission and supporting documentation adequately demonstrate that the rates were developed using generally accepted actuarial practices and principles, CMS will consider whether the submission demonstrates the following:

a. all adjustments to the capitation rates, or to any portion of the capitation rates, must reflect reasonable, appropriate, and attainable costs in the actuary's judgment and must be included in the rate certification.

b. adjustments to the rates that are performed outside of the rate setting process described in the rate certification are not considered actuarially sound under 42 CFR §438.4. Therefore, the rates will not be considered actuarially sound if adjustments are made outside of the rate setting process described in the rate certification.

c. consistent with 42 CFR §438.7(c), the final contracted rates in each cell must match the capitation rates in the rate certification. This is required in total and for each and every rate cell.

viii. Rates must be certified for all time periods in which they are effective, and a certification must be provided for rates for all time periods. Rates from a previous rating period cannot be used for a future time period without an actuarial certification of the rates for the new rating period.

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

a. if a state intends to claim Federal financial participation (FFP) for capitation rates, the state must comply with the same time limit for filing claims for FFP specified in section 1132 of the Social Security Act and implementing regulations at 45 CFR part 95. States should timely submit rate certifications to CMS to help mitigate timely filing concerns.

b. the state must submit a revised rate certification when the rates change, except for changes permitted in 42 CFR §438.7(c)(3).

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

Section I. Medicaid Managed Care Rates	
• **General Information**	
c. for contract amendments that do not affect the rates (except for changes permitted in 42 CFR §438.7(c)(3)), CMS does not require a rate amendment from the state. However, if the contract amendment revises the covered populations, services furnished under the contract or other changes that could reasonably change the rate development and rates, the state and its actuary must provide supporting documentation indicating the rationale as to why the rates continue to be actuarially sound in accordance with 42 CFR §438.4. d. there are several circumstances when CMS would not require a rate amendment: i. the state may increase or decrease capitation rate per rate cell up to 1.5 percent range, in accordance with 42 CFR §438.7(c)(3). ii. a state applies risk scores to the capitation rates paid to the plans under a risk adjustment methodology described in the rate certification for that rating period and contract, in accordance with 42 CFR §438.7(b)(5)(iii). e. any time a rate changes for any reason other than application of an approved payment term (e.g., risk adjustment methodology), which was included in the initial managed care contract, the state must submit a contract amendment to CMS, even if the rate change does not need a rate amendment. f. State Medicaid program features are sometimes invalidated by courts of law, or by changes in federal statutes, regulations or approvals. A state must submit a rate amendment adjusting capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. The rate amendment must take into account the effective date of the loss of program authority.	
B. Appropriate Documentation	**Documentation Reference**
i. States and their actuaries must document all the elements described within their rate certification to provide adequate detail that CMS is able to determine whether or not the regulatory standards are met. In evaluating the rate certification, CMS will look to the reasonableness of the information contained in the rate certification for the purposes of rate development and may require additional information or	• Mercer Rate Certification

Section I. Medicaid Managed Care Rates	
• General Information	
documentation as necessary to review and approve the rates. States and their actuaries must ensure that the following elements are properly documented: a. data used, including citations to studies, research papers, other states' analyses, or similar secondary data sources. b. assumptions made, including any basis or justification for the assumption. c. methods for analyzing data and developing assumptions and adjustments.	
ii. CMS understands that there are instances where actuaries develop ranges around various assumptions and adjustments. We believe this is a valid and appropriate approach to aid in the development and selection of the final assumptions that underlie the certified capitation rates, but note that actuaries must certify specific rates for each rate cell in accordance with 42 CFR § 438.4(b)(4) and 438.7(c), and it is not permissible to certify rate ranges. Therefore, the actuary must be responsible for all assumptions and adjustments underlying the certified capitation rates, and the certification must disclose and support the specific assumptions that underlie the certified rates for each rate cell, including the magnitude and narrative support for each specific assumption or adjustment that underlies the certified rates for each rate cell. To the extent assumptions or adjustments underlying the capitation rates varies between	

Section I. Medicaid Managed Care Rates	
• **General Information**	
managed care plans, the certification must also describe the basis for this variation.	
iii. The rate certification must include an index that identifies the page number or the section number for each item described within this guidance. In cases where not all sections of this guidance are relevant for a particular rate certification (i.e., an amended certification that adds a new benefit for part of the year), inapplicable sections of guidance must be included and marked as "Not Applicable" in the index. CMS prefers that the rate certification include an index and also follow the structure of this guidance.	
iv. There are services, populations, or programs for which the state receives a different federal medical assistance percentage (FMAP) than the regular state FMAP. In those cases, the portions or amounts of the costs subject to the different FMAP must be separately shown as part of the rate certification to the extent possible.	• Mercer Rate Certification: — Dental Capitation Rates, Page 2
v. CMS requests that states that operated the managed care program or programs covered by the rate certification in previous rating periods provide: a. A comparison to the final certified rates in the previous rate certification. For the first rate certification for a rating period, this should be a comparison to the prior rating period's rates or rate ranges. For rate certifications that revise or amend	• Mercer Rate Certification: — Rates Comparison, Page 2

Section I. Medicaid Managed Care Rates	
• **General Information**	
rates in a rating period, this should be a comparison to the latest certified rates for the rating period. If there are large or negative changes in rates from the previous year, the actuary must describe what is leading to these differences. b. A description of any other material changes to the capitation rates or the rate development process compared to the prior rating period (or compared to the latest rate certification for rate certifications that amend rates) not otherwise addressed in the other sections of this guidance.	
vi. The rate certification should include a list of known amendments that will be provided to CMS in the future, when the state expects the amendments will be submitted to CMS, and why the current certification cannot account for changes that are anticipated to be made to the rates.	

Section I. Medicaid Managed Care Rates
• **Data**
A. Rate Development Standards
i. In accordance with 42 CFR §438.5(c), states and actuaries must follow rate development standards related to base data, including: a. states must provide all the validated encounter data and/or fee-for-service (FFS) data (as appropriate) and audited financial reports (as defined in see §438.3(m)) that demonstrates experience for the populations to be served by the health plan to the state's actuary developing the capitation rates for at least the three most recent and complete years prior to the rating period.

Section I. Medicaid Managed Care Rates	
• **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 CFR §438.5(c)(1)-(2). ii. the request must describe why an exception is necessary and describe the actions the state intends to take to come into compliance with those requirements. iii. the request must also describe the state's proposed corrective action plan outlining how the state will come into compliance with the base data standards per 42 CFR §438.5(c) no later than two years from the rating period for which the deficiency is identified.	
B. Appropriate Documentation	**Documentation Reference**
i. In accordance with 42 CFR §438.7(b)(1), the rate certification must include: a. a description of base data requested and used for the rate setting process, including: i. a summary of the base data that was requested by the actuary. ii. a summary of the base data that was provided by the state.	• Mercer Rate Certification: — Base Data, Page 4

Section I. Medicaid Managed Care Rates	
• **Data**	
iii. an explanation of why any base data requested was not provided by the state.	
ii. The rate certification, as supported by the assurances from the state, must thoroughly describe the data used to develop the capitation rates, including: a. a description of the data, including:	
• the types of data used, which may include, but is not limited to: fee-for-service claims data; managed care encounter data; health plan financial data; information from program integrity audits; or other Medicaid program data.	• Mercer Rate Certification: — Base Data, Page 4
• the age or time periods of all data used.	• Mercer Rate Certification: — Base Data, Page 4
• the sources of all data used (e.g., State Medicaid Agency; other state agencies; health plans; or other third parties).	• Mercer Rate Certification: — Base Data, Page 4
• if a significant portion of the benefits under the contract with the managed care entity are provided through arrangements with subcontractors that are also paid on a capitated basis (or subcapitated arrangements), a description of the data received from the subcapitated plans or providers; or, if data is not received from the subcapitated plans or providers, a description of how	N/A

Section I. Medicaid Managed Care Rates	
• **Data**	
the historical costs related to subcapitated arrangements were developed or verified.	
b. information related to the availability and the quality of the data used for rate development, including:	
i. the steps taken by the actuary or by others (e.g., State Medicaid Agency; health plans; external quality review organizations; financial auditors; etc.) to validate the data, including: A. completeness of the data. B. accuracy of the data. C. consistency of the data across data sources.	• Mercer Rate Certification: — Base Data, Page 4 — Under-Reporting, Page 5 — Completion Factors, Pages 5 and 6
ii. a summary of the actuary's assessment of the data.	• Mercer Rate Certification: — Base Data, Page 4 — Certification of Rates, Pages 9–11
iii. any concerns that the actuary has over 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 fee-for-service claims or managed care encounter data are not used (or are not available), this description should include an explanation of why the data used in	N/A

Section I. Medicaid Managed Care Rates	
• **Data**	
rate development is appropriate for setting capitation rates for the populations and services to be covered.	
ii. if managed care encounter data was not used in the rate development, this description should include an explanation of why encounter data was not used as well as any review of the encounter data and the concerns identified which led to not including the encounter data.	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 significant adjustments, and the basis for the adjustments, that are made to the data, including but not limited to adjustments for:	
• the credibility of the data.	• Mercer Rate Certification: — Base Data, Page 4 — Certification of Rates, Pages 9–11
• completion factors.	• Mercer Rate Certification: — Completion Factors, Pages 5 and 6
• errors found in the data.	N/A

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• **Data**	
• 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).	N/A
• exclusions of certain payments or services from the data.	• Mercer Rate Certification: — Institution of Mental Diseases, Pages 4 and 5

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A. Rate Development Standards	
i. Final capitation rates must be based only upon the services allowed in 42 CFR §438.3(c)(1)(ii) and 438.3(e).	
ii. Variations in the assumptions used to develop the projected benefit costs for covered populations must be based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations.	
iii. In accordance with 42 CFR §438.5(d), each projected benefit cost trend assumption must be reasonable and developed in accordance with generally accepted actuarial principles and practices. Trend assumptions must be developed primarily from actual experience of the Medicaid population or from a similar population and include consideration of other factors that may affect projected benefit cost trends through the rating period.	
iv. If the projected benefit costs include costs for in-lieu-of services defined at 42 CFR §438.3(e)(2) (i.e., substitutes for State Plan services or settings), the utilization and unit costs of the in-lieu-of services must be taken into account in developing the projected benefit costs of	

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the covered services (as opposed to utilization and unit costs of the State plan services or settings), unless a statute or regulation explicitly requires otherwise. The costs of an IMD as an in-lieu-of-service must not be used in rate development. See Section I, item 3.A.v of this guide.	
v. When IMDs are used to provide in-lieu-of services, states may make a monthly capitation payment to an MCO or PIHP under a "risk contract" (as defined in 42 CFR §438.2) for an enrollee age 21 to 64 receiving inpatient treatment in an IMD (as defined in 42 CFR §435.1010) for a short-term stay of no more than 15 days during the period of the monthly capitation payment in accordance with 42 CFR §438.6(e). In this case, when developing the projected benefit costs for these services, the actuary must use the unit costs of providers delivering the same services included in the State Plan, as opposed to the unit costs of the IMD services. The actuary may use the utilization of the services provided to an enrollee in an IMD in developing the utilization component of projected benefit costs. The data used for developing the projected benefit costs for these services must not include: a. costs associated with an IMD stay of more than 15 days. b. any other costs for any services delivered during the time an enrollee is in an IMD for more than 15 days.	
B. Appropriate Documentation	**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 plans).	• Mercer Rate Certification — Dental Capitation Rates, Table 1-1, Page 2
ii. The rate certification and supporting documentation must describe the development of the projected benefit costs included in the capitation rates, including:	
• a description of the data, assumptions, and methodologies used to develop the projected benefit costs and, in particular, all significant and material items in developing the projected benefit costs.	• Mercer Rate Certification, Pages 2–9

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• any material changes to the data, assumptions, and methodologies used to develop projected benefit costs since the last rate certification must be described.	
• the amount of overpayments to providers and a description of how the state accounted for this in rate development. See §438.608(d).	• Mercer Rate Certification, Pages 2–9
iii. The rate certification and supporting documentation must include a section on projected benefit cost trends (i.e. an estimate the projected change in benefit costs from the historical base data period(s) to the rating period of the rate certification) in accordance with 42 CFR §438.7(b)(2). a. this section must include:	
• any data used or assumptions made in developing projected benefit cost trends, including a description of the sources of those data and assumptions. • 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. • the description should state whether the trend is developed primarily with actual experience from the Medicaid population or provide rationale for the	• Mercer Rate Certification: — Trend Adjustments, Pages 6 and 7

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experience from a similar population that is utilized, and consideration of other factors expected to impact trend.	
• the methodologies used to develop projected benefit trends.	• Mercer Rate Certification: — Trend Adjustments, Pages 6 and 7
• 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, Pages 6 and 7
• documentation supporting the chosen trend rates and explanation of outlier and negative trends.	
b. this section must include the projected benefit cost trends separated into components, specifically:	
i. the projected benefit cost trends should be separated into: A. changes in price (i.e., pricing differences due to different provider reimbursement rates or payment models); and B. changes in utilization (i.e., differences in the amount, duration, or mix of benefits or services provided).	N/A

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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.	• Mercer Rate Certification: — Trend Adjustments, Pages 6 and 7
iii. the projected benefit cost trends may include other components as applicable and used by the actuary in developing rates (e.g., changes in location of service delivery; the effect of utilization or care management on projected benefit cost trends; regional differences or variations).	N/A
c. variations in the projected benefit cost trends must be explained. Projected benefit cost trends may vary by: i. Medicaid populations. ii. rate cells. iii. subsets of benefits within a category of services (e.g., specialty vs. non-specialty drugs).	N/A
d. any other material adjustments to projected benefit cost trends must be described in accordance with 42 CFR §438.7(b)(4), including: i. a description of the data, assumptions, and methodologies used to determine each adjustment. ii. the cost impact of each material adjustment.	N/A

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iii. where in the rate setting process the material adjustment was applied.	
e. any other adjustments to projected benefit costs trends must be listed. CMS also requests the following detail about non-material adjustments: i. the impact of managed care on the utilization and the unit costs of health care services. ii. changes to projected benefit costs trend in the rating period outside of regular changes in utilization or unit cost of services.	N/A
iv. If the projected benefit costs include additional services deemed by the state to be necessary to comply with the mental health parity standards in 42 CFR Part 438, subpart K[5] as required by 42 CFR §438.3(c)(1)(ii), the following must be described: a. the categories of service that contain these additional services necessary for parity. b. the percentage of cost that these services represent in each category of service.	N/A

[5] 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 1832 of the Act.

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c. how these services were taken into account in the development of the projected benefit costs, and if this approach was different than that for any of the other services in the categories of service. d. An assurance that the payment represents a payment amount that is adequate to allow the MCO, PIHP or PAHP to efficiently deliver covered services to Medicaid-eligible individuals in a manner compliant with contractual requirements.	
v. For in-lieu-of services defined at 42 CFR §438.3(e)(2) (i.e., substitutes for State Plan services), the following information must be provided and documented: a. the categories of covered service that contain in-lieu-of-services. b. the percentage of cost that in-lieu-of services represent in each category of service. c. how the in-lieu-of services were taken into account in the development of the projected benefit costs, and if this approach was different than that for any of the other services in the categories of service. d. for inpatient psychiatric or substance use disorder services provided in an IMD setting, rate development must comply with the requirements of 42 CFR §438.6(e) and the data and assumptions utilized should be described in the rate certification. The costs of an IMD as an in-lieu-of-service	N/A

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must not be used in rate development. See Section I, item 3.A.v of this guide.	
vi. The rate certification must describe how retrospective eligibility periods are accounted for in rate development, including but not limited to: a. the managed care plan's responsibility to pay for claims incurred during the retroactive eligibility period. b. how the claims information are included in the base data. c. how the enrollment or exposure information is included in the base data. d. how the capitation rates are adjusted to reflect the retroactive eligibility period, and the assumptions and methodologies used to develop those adjustments.	• Mercer Rate Certification: — Retroactive Eligibility, Page 4
vii. The rate certification must clearly document the impact on projected costs for all material changes to covered benefits or services since the last rate certification, including, but not limited to: a. more or fewer state plan benefits covered by Medicaid managed care. b. any recoveries of overpayments made to providers by health plans in accordance with 42 CFR §438.608(d). c. requirements related to payments from health plans to any providers or class of providers.	N/A

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d. requirements or conditions of any applicable waivers. e. requirements or conditions of any litigation to which the state is subjected.	
viii. For each change related to covered benefits or services, the rate certification must include an estimated impact of the change on the amount of projected benefit costs and a description of the data, assumptions, and methodologies used to develop the adjustment.	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.	

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• Special Contract Provisions Related to Payment

A. Incentive Arrangements

i. Rate Development Standards

a. the rate certification and supporting documentation must describe any incentives included in the contract between the state and the health plans. An incentive arrangement, as defined in 42 CFR §438.6(a), is any payment mechanism under which a health plan may receive additional funds over and above the capitation rate it was paid for meeting targets specified in the contract.

i. the rate certification must include documentation that the total payments under the incentive arrangement (i.e., capitation rate payments plus incentive payments) will not exceed 105 percent of the approved capitation payments under the contract that are attributable to the enrollees or services covered by the incentive arrangements as required in 42 CFR §438.6(b)(2).

ii. Appropriate Documentation	**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

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

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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 certified capitation rates being withheld through withhold arrangements. v. an estimate of the percentage of the withheld amount in a withhold arrangement that is not reasonably achievable and the basis for that determination, including the data, assumptions, and methodologies used to make this determination. vi. a description of how the total withhold arrangement, achievable or not, is reasonable and takes into consideration the health plan's financial operating needs accounting for the size and characteristics of the populations covered under the contract, as well as the health plan's capital reserves as measured by the risk-based capital level, months of claims reserve, or other appropriate measure of reserves. vii. a description of any effect that each withhold arrangement has on the development of the capitation rates.	

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b. the actuary must certify capitation payment(s) minus any portion of the withhold that is not reasonably achievable as actuarially sound.	
C. Risk-Sharing Mechanisms	
i. Rate Development Standards a. in accordance with 42 CFR §438.6(b), if the state utilizes risk-sharing mechanisms with its health plan(s), such as reinsurance, risk corridors, or stop-loss limits, these arrangements must be described in the contract(s) and must be developed in accordance with §438.4, the rate development standards in §438.5, and generally accepted actuarial principles and practices. b. the rate certification and supporting documentation must describe any risk mitigation that may affect the rates or the final net payments to the health plan(s) under the applicable contract.	
ii. Appropriate Documentation	**Documentation Reference**
a. the rate certification and supporting documentation must include a description of any other risk-sharing arrangements, such as a risk corridor or a large claims pool. An adequate description of these includes at least the following: i. a rationale for the use of the risk sharing arrangement. ii. a detailed description of how the risk-sharing arrangement is implemented.	N/A

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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 include a description of this MLR arrangement. An adequate description includes at least the following: i. the methodology used to calculate the medical loss ratio. ii. the formula for calculating a remittance/payment for having a medical loss ratio below/above the minimum requirements. iii. any other consequences for a remittance/payment for a medical loss ratio below/above the minimum requirements.	• Mercer Rate Certification: — Minimum Medical Loss Ratio, Page 9
c. if the contract has reinsurance requirements, the rate certification and supporting document must include a description of the reinsurance requirements. An adequate description includes at least the following:	

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i. a detailed description of any reinsurance requirements under the contract associated with the rate certification, including the reinsurance premiums and any relevant historical reinsurance experience. ii. identification of any effect that the reinsurance requirements have on the development of the capitation rates. iii. documentation that the reinsurance mechanism has been developed in accordance with generally accepted actuarial principles and practices. iv. if the actuary develops the reinsurance premiums, a description of how the reinsurance premiums were developed, including the data, assumptions and methodology used.	
D. Delivery System and Provider Payment Initiatives	
i. Rate Development Standards a. consistent with 42 CFR §438.6(c), states may utilize delivery system and provider payment initiatives, including requiring managed care plans to:[6]	

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

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i. implement value-based purchasing models for provider reimbursement, such as pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services.

ii. participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

iii. adopt a minimum fee schedule for network providers that provide a particular service under the contract.

iv. provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract.

v. adopt a maximum fee schedule for network providers that provide a particular service under the contract, so long as the health plan retains the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

b. The state's rate certification for the applicable period must address how each payment arrangement approved by CMS under 42 CFR 438.6(c) is reflected in the payments to the managed care plan from the state. Such payment arrangements can be incorporated into the base capitation rates as an adjustment to the rate or addressed through a separate payment term. When the payment arrangement is addressed through a separate payment term, CMS's expectations are as follows:

i. documentation related to the payment term will be included in the initial rate certification as outlined in Section I, Item 4.D.ii.a.iii of the guide.

ii. when a material portion of the total capitation payment to the managed care plan for any rate cell is for directed payments addressed through separate payment terms, an estimate of the magnitude of that portion of the payment on a PMPM basis for each rate cell (CMS recognizes that this is an estimate, and that the state will provide the final figures after the payment has been made).

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

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iv. please note, if the total amount of the payment or distribution methodology is changed from the initial rate certification, CMS expects the state to submit a rate amendment for the rating period, and clearly describe the magnitude of and the reason for the change.	
ii. Appropriate Documentation	**Documentation Reference**
a. the rate certification and supporting documentation must include a description of each delivery system and provider payment initiative. The documentation needed depends on which approach the state has used to incorporate the payment into its rate certification. Please provide the following information for each delivery system and provider payment initiative:	
i. a brief description of the delivery system and provider payment initiative(s) included in the rates for this rating period, including: A. the type of directed payment arrangement (minimum fee schedule, maximum fee schedule, bundled payment, etc.). B. a brief description (e.g. minimum fee schedule is set at $x as approved in the Medicaid state plan, minimum fee schedule is set at y% of Medicare, etc.).	N/A
ii. If a payment will be incorporated into the rate certification in the base capitation rates as a rate	N/A

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adjustment, then the following information should be included in the state's rate certification (please include this information for each separate directed payment arrangement): A. an indication of which rate cells were affected by the directed payment arrangement. B. the impact the directed payment has on the rates, for each rate cell. C. a description of how the payment arrangement is reflected in the certified capitation rates. To the extent an adjustment is applied to account for the impact of the payment arrangement or changes to the payment arrangement from the base data period, the actuary should provide a description of the data, assumptions, and methodologies used to develop the adjustment. D. an indication that the payment is being made under an approved §438.6(c) payment arrangement in a manner that is consistent with the pre-print (including any correspondence between the state and CMS regarding the pre-print) reviewed by CMS. To the extent the payment arrangement has not been approved by CMS before the actuary certifies the capitation rates, this should be noted in the certification and the payment arrangement that is	

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under review should still be accounted for in rate development. In this case, the actuary should also provide an indication that the payment arrangement is accounted for in a manner consistent with the pre-print that is under CMS review. If the preprint has not yet been submitted to CMS for review, the certification should indicate when the preprint will be submitted to CMS. E. if implementing a maximum fee schedule, the actuary should explain if there are any instances in the base data where the plans paid above the maximum fee schedule and how the actuary determined that it was reasonable to assume that the plans that currently pay above the maximum fee schedule will be able to lower their reimbursement rates consistent with the maximum fee schedule requirement. The actuary should also explain whether there are any exemptions to the maximum fee scheduled which allow for plans to pay above the maximum fee schedule during the rating period and how these exemptions were considered in rate development.	
iii. if the payment will be incorporated into the initial rate certification as a separate payment term, then the following information should be included in the state's	

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rate certification (please include this information for each separate directed payment arrangement):

A. the aggregate amount of the payment applicable to the rate certification.

B. an explicit statement from the actuary that he or she certifies the amount of the separate payment term disclosed in the certification (i.e. the amount in Section I, Item 4.D.ii.a.iii.A).

C. the provider types that will be receiving the payment.

D. the distribution methodology.

E. an estimate of the magnitude of the payment on a PMPM basis for each rate cell (CMS recognizes that this is an estimate, and that the state will provide the final figures after the payment has been made).

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

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development. In this case, the actuary should also provide an indication that the payment arrangement is accounted for in a manner consistent with the pre-print that is under CMS review. If the preprint has not been submitted to CMS for review, the certification should indicate when the preprint will be submitted to CMS. G. a statement that after the rating period is complete the state will submit (to CMS) documentation that incorporates the total amount of the payment into the rate certification's rate cells consistent with the distribution methodology described in the initial rate certification, and as if the payment information (e.g., providers receiving the payment, amount of the payment, utilization that occurred, enrollees seen, etc.) had been fully known when the rates were initially developed.	
b. The rate certification and supporting documentation must confirm that there are not any additional directed payments in the program that are not addressed in the certification.	N/A
c. he rate certification and supporting documentation must confirm that there are not any requirements regarding the reimbursement rates the plans must pay to any providers unless specifically specified in the certification as a directed	

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payment or authorized under applicable law, regulation, or waiver.

E. Pass-Through Payments

i. Rate Development Standards

a. a pass-through payment, as defined in 42 CFR §438.6(a), is any amount required by the state to be added to the contracted payment rates, and considered in calculating the actuarially sound capitation rate, between MCOs, PIHPs, or PAHPs and hospitals, physicians, or nursing facilities that is not for one of the following purposes: [7,8]

i. a specific service or benefit provided to a specific enrollee covered under the contract;

ii. a provider payment methodology permitted under 42 CFR §438.6(c)(1)(i) through (iii) for services and enrollees covered under the contract;

iii. a subcapitated payment arrangement for a specific set of services and enrollees covered under the contract;

iv. Graduate Medical Education (GME) payments; or

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

b. pass-through payments are allowed for transition periods as outlined in 42 CFR §438.6(d). In order to use a transition period, a state must demonstrate that it had pass-through payments for hospitals, physicians, or nursing facilities, as defined in 42 CFR §438.6(d)(1)(i), in:[9]

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

[8] 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.

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

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i. managed care contract(s) and rate certification(s) for the rating period that includes July 5, 2016, and were submitted for CMS review and approval on or before July 5, 2016; or

ii. if the managed care contract(s) and rate certification(s) for the rating period that includes July 5, 2016 had not been submitted to CMS on or before July 5, 2016, the managed care contract(s) and rate certification(s) for a rating period before July 5, 2016 that had been most recently submitted for CMS review and approval as of July 5, 2016.

c. pass-through payments to hospitals must comply with the requirements of 42 CFR §438.6(d).

i. in accordance with 42 CFR §438.6(d)(3), the aggregate pass-through payments to hospitals may not exceed the lesser of: (1) 80 percent of the base amount; or (2) the total dollar amount of pass-through payments to hospitals identified in the managed care contract(s) and rate certification(s) used to meet the requirement of 42 CFR §438.6(d)(1)(i).

ii. in accordance with 42 CFR §438.6(d)(5), the aggregate pass-through payments to physicians or nursing facilities may be no more than the total dollar amount of pass-through payments to physicians or nursing facilities, respectively, identified in the managed care contract(s) and rate certification(s) used to meet the requirement of 42 CFR §438.6(d)(1)(i).

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

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

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

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

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

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

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

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

f. the impact of any §438.6(c) directed payments made to hospitals during the 12-month period immediately 2 years prior to the rating period should be included when calculating amounts in Section I, Item 4.E.i.d.i.B of the guide.

g. in accordance with 42 CFR §438.6(d)(2)(iv), states may calculate reasonable estimates of the aggregate differences in paragraph (d) in accordance with the upper payment limit requirements in 42 CFR part 447.

i. if the state chooses to utilize a trend adjustment when calculating reasonable estimates of the aggregate differences in paragraph (d), it must provide a justification of why an adjustment is reasonable and appropriate, and the state should utilize the same data source for the trend adjustments when calculating amounts in Section I, Item 4.E.i.d.i.A, Section I, 4.E.i.d.i.B, Section I, Item 4.E.i.d.ii.A, and Section I, 4.E.i.d.ii.B of this guide.

h. capitation rates may only include pass-through payments to hospitals, physicians and nursing facilities when permitted by 42 CFR §438.6(d); states may not include pass-through payments to providers other than hospitals, physicians, and nursing facilities in the capitation rates.

i. if a state chooses to include a pass-through payment as a per member per month (PMPM) amount, tied to enrollment, the state must monitor the actual pass-through payment amounts paid during the rating period to ensure it does not exceed the amount

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• **Special Contract Provisions Related to Payment**	
permitted under 42 CFR 438.6(d) to ensure compliance with the regulation. If the actual enrollment were to vary in a way that increases the pass-through payments beyond that allowable amount, the state must amend the rates to comply with Federal requirements. Additionally, the state must include the maximum dollar amount of the pass-through payment amounts permitted under 42 CFR 438.6(d) within its contracts with managed care plans.	
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. the amount of the pass-through payment, both in total and on a per member per month basis (if applicable). iii. the program(s) that includes the pass-through payment. iv. the providers receiving the pass-through payment. v. the financing mechanism for the pass-through payment. vi. Identification of any §438.6(c) directed payment arrangement(s) which target the same providers receiving the pass-through payment.	N/A
b. The rate certification and supporting documentation must include a description of the aggregate pass-through	N/A

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payments incorporated into the rates for this rating period by provider type. An adequate description includes at least the following for the pass-through payments by provider type:

i. the amount of pass-through payments by provider type both in total and on a per member per month basis (if applicable).

ii. documentation of historical pass-through payments by provider type that are a prerequisite for authorization to use a transition period (as outlined in 42 CFR §438.6(d)(1)(i)):

A. if the managed care contract(s) and rate certification(s) for the rating period that includes July 5, 2016 were submitted to CMS on or before July 5, 2016, please provide:

1. the total aggregate amount of pass-through payments per provider type (i.e. hospital physician and nursing facility) incorporated into capitation rates for the rating period in effect on July 5, 2016.

2. the date(s) the managed care contract(s) and rate certification(s) were submitted to CMS for review and approval.

B. if the managed care contract(s) and rate certification(s) for the rating period that includes July

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• **Special Contract Provisions Related to Payment**	
5, 2016 had not been submitted to CMS on or before July 5, 2016, please provide: 1. the total aggregate amount of pass-through payments by provider type incorporated into capitation rates for the rating period before July 5, 2016 that had been most recently submitted for CMS review and approval as of July 5, 2016. c. The dates(s) the managed care contract(s) and rate certification(s) were submitted to CMS for review and approval.	
d. in accordance with 42 CFR §438.6(d)(4), the certification must document the following information about the base amount for hospital pass-through payments: i. the data, methodologies, and assumptions used to calculate the base amount, including the data, methodologies and assumptions for any reasonable estimate(s) utilized. i. The description must include a summary of any adjustment made to the base data used to calculate amounts for Section I, Item 4.E.i.d.i.A, Section I, 4.E.i.d.i.B, Section I, Item 4.E.i.d.ii.A, and Section I, 4.E.i.d.ii.B of the guide, including a rationale and fiscal impact of each adjustment.	N/A

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ii. the aggregate amounts calculated for Section I, Item 4.E.i.d.i.A, Section I, Item 4.E.i.d.i.B, Section I, Item 4.E.i.d.ii.A, and Section I, 4.E.i.d.ii.B of this guide.

iii. if the state chooses to utilize trend adjustments when calculating the amounts identified in Section I, Item 4.E.i.d.i.A, Section I, 4.E.i.d.i.B, Section I, Item 4.E.i.d.ii.A, and Section I, 4.E.i.d.ii.B of the guide, the state must ensure clear documentation, including:

i. explanation of the purpose of the trend adjustment (e.g. cost inflation, utilization, etc.) and justification of why an adjustment is reasonable and appropriate.

ii. the trend adjustment applied to amounts, as applicable, in Section I, Item 4.E.i.d.i.A, Section I, 4.E.i.d.i.B, Section I, Item 4.E.i.d.ii.A, and Section I, 4.E.i.d.ii.B of the guide.

iii. a description of the data source, assumptions, and methodology used to determine each adjustment.

iv. the fiscal impact of each trend adjustment.

v. if the state does not utilize a consistent data source for the trend adjustment used in the base amount calculation and demonstrations of upper payment limits requirements for inpatient and outpatient hospital services in accordance with 42 CFR 447, the state must provide a clear rationale of why a different data source is reasonable and appropriate

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• **Special Contract Provisions Related to Payment**	
for the trend adjustments used in the base amount calculation. iv. the calculation of the applicable percentage of the base amount available for pass-through payments under the schedule in Section I, Item 4.E.i.c. of the guide. v. the amount of any §438.6(c) directed payment arrangements made to hospitals during the 12-month period immediately 2 years prior to the rating period, and an explanation of how these were included in the calculations of amounts in Section I, Item 4.E.i.d.i.B of the guide.	

Section I. Medicaid Managed Care Rates
• **Projected Non-Benefit Costs**
A. Rate Development Standards
i. In accordance with 42 CFR §438.5(e), the development of the non-benefit component of the rate must include reasonable, appropriate, and attainable expenses related to MCO, PIHP or PAHP administration, taxes, licensing and regulatory fees, contribution to reserves, risk margin, and cost of capital. In addition, the non-benefit component must include other operational costs associated with the provision of services under the contract, including those administrative costs for compliance with mental health parity standards in 42 CFR 438.3, subpart K.
ii. Non-benefit costs may be developed as per member per month (PMPM) costs or as a percentage of projected benefit costs or capitation rates, and different approaches can be taken for different categories of costs. For non-benefit costs that may be difficult to allocate to

Section I. Medicaid Managed Care Rates

- **Projected Non-Benefit Costs**

specific enrollees or groups of enrollees, or for taxes and fees that are assessed as a percentage of premiums, it may be reasonable to calculate those non-benefit costs as a percentage of benefit costs or capitation rates.

iii. Variations in the assumptions used to develop the projected non-benefit costs for covered populations must be based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations.

iv. Section 9010 of the Patient Protection and Affordable Care Act imposes a Health Insurance Providers Fee on each covered entity engaged in the business of providing health insurance for United States health risk. CMS policy regarding how this fee may be considered in Medicaid managed care rate development is outlined in CMS's "Medicaid and CHIP FAQs: Health Insurance Providers Fee for Medicaid Managed Care Plans," dated October 2014.[10] States have the flexibility to account for the Health Insurance Providers Fee on a prospective or retrospective basis into rate development for either the data year or fee year. Any payment for the fee must be incorporated in the health plan capitation rates.

a. due to the health insurance provider fee moratorium established by the Consolidated Appropriations Act of 2016 and continuing resolution legislation, Pub. Law. 115-120 (H.R. 195), Division D – Suspension of Certain Health-Related Taxes, § 4003,CMS does not expect any health insurance provider fees to be paid for calendar year 2017 and 2019 by managed care plans that are subject to that fee. Therefore, no amounts should be included in Medicaid managed care capitation rates for fees that would have been paid by plans to the IRS for 2017 or 2019 (which would have been assessed off of 2016 and 2018 net premiums, respectively).[11] This fee remains in effect for calendar year 2018 and 2020. The Further Consolidated Appropriations Act, 2020, Division N, Subtitle E § 502 repealed the annual fee on health insurance providers for calendar years beginning after December 31, 2020.

[10] https://www.medicaid.gov/federal-policy-guidance/downloads/faq-10-06-2014.pdf
[11] More information on this issue can be found at: https://www.irs.gov/Businesses/Corporations/Affordable-CareAct-Provision-9010

Section I. Medicaid Managed Care Rates	
• **Projected Non-Benefit Costs**	
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 CFR §438.7(b)(3). To meet this standard, the documentation must include: a. a description of the data, assumptions, and methodologies used to develop the projected non-benefit costs, and in particular, all significant and material items in developing the projected non-benefit costs. b. any material changes to the data, assumptions, and methodologies used to develop projected non-benefit costs since the last rate certification. c. any other material adjustments must be described in accordance with 42 CFR §438.7(b)(4), including: i. a description of the data, assumptions, and methodologies used to determine each adjustment. ii. where in the rating setting process each adjustment was applied. iii. the cost impact of each material adjustment.	• Mercer Rate Certification: — Non-Medical Expense Load, Page 9

Section I. Medicaid Managed Care Rates	
• **Projected Non-Benefit Costs**	
ii. States and actuaries should estimate the projected non-benefit costs for each of the following categories of costs: • administrative costs. • taxes, licensing and regulatory fees, and other assessments and fees. • contribution to reserves, risk margin, and cost of capital. • 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, Page 9
iii. Actuaries should disclose historical non-benefit cost data in the certification to the extent this information was provided by the plans, and explain how the historical non-benefit cost data was considered in the non-benefit cost assumptions used in the rate development.	• Mercer Rate Certification: — Non-Medical Expense Load, Page 9
iv. Regarding the Health Insurance Providers Fee, the rate certification and supporting documentation must: a. specifically address how this fee is incorporated into capitation rates if the managed care plan is required to pay the fee for 2020. b. if the fee is incorporated into the rates in the initial rate certification, an explanation of whether the amount included in the rates is based on the data year or fee year during the rating period of the rate certification.	

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

Section I. Medicaid Managed Care Rates

- **Risk Adjustment and Acuity Adjustments**

A. Rate Development Standards

i. Risk adjustment is a methodology to account for the health status of enrollees via relative risk factors when predicting or explaining costs of services covered under the contract for defined populations or for evaluating retrospectively the experience of MCOs, PIHPs, or PAHPs contracted with the state.

ii. As required by 42 CFR §438.5(g), if risk adjustment is applied prospectively or retrospectively, states and their actuaries must select a risk adjustment methodology that uses generally accepted models and must apply it in a budget neutral manner, consistent with generally accepted actuarial principles and practices, across all MCOs, PIHPs or PAHPs in the program to calculate adjustments to the payments as necessary.

iii. An adjustment applied to the total payments across all managed care plans to account for significant uncertainty about the health status or risk of a population is considered an acuity adjustment, which is a permissible adjustment under 42 CFR §438.5(f) (81 FR 27595).

   a. acuity adjustments may be used prospectively or retrospectively.

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

   c. CMS may also consider acuity adjustments as a risk mitigation strategy when there is unusual and significant uncertainty about the health status of the population (e.g., covering a new population in Medicaid).

Section I. Medicaid Managed Care Rates	
• Risk Adjustment and Acuity Adjustments	
B. Appropriate Documentation	**Documentation Reference**
i. In accordance with 42 CFR §438.7(b)(5)(i), the rate certification must describe all prospective risk adjustment methodologies, including: a. the data, and any adjustments to that data, to be used to calculate the adjustment. b. the model, and any adjustments to that model, to be used to calculate the adjustment. c. the method for calculating the relative risk factors and the reasonableness and appropriateness of the method in measuring the risk factors of the respective populations. d. the magnitude of the adjustment on the capitation rate per MCO, PIHP, or PAHP. e. an assessment of the predictive value of the methodology compared to prior rating periods. f. any concerns the actuary has with the risk adjustment process.	N/A
ii. In accordance with 42 CFR §438.7(b)(5)(ii), the rate certification must describe all retrospective risk adjustment methodologies, including: a. the party calculating the risk adjustment. b. the data, and any adjustments to that data, to be used to calculate the adjustment.	N/A

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• **Risk Adjustment and Acuity Adjustments**	
c. the model, and any adjustments to that model, to be used to calculate the adjustment. d. the timing and frequency of the application of the risk adjustment. e. any concerns the actuary has with the risk adjustment process.	
iii. The rate certification and supporting documentation must also specifically include: a. any changes that are made to risk adjustment models since the last rating period. b. documentation that the risk adjustment model is budget neutral in accordance with 42 CFR §438.5(g).	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 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.	

Section I. Medicaid Managed Care Rates

• Risk Adjustment and Acuity Adjustments

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
   b. by the long-term care setting that the beneficiary uses ("non-blended").

Section II. Medicaid Managed Care Rates with Long-Term Services and Supports	
1. Managed Long-Term Services and Supports	
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 plans that transition beneficiaries from institutional long-term care settings into other settings, or may pay adjusted rates during time periods of setting transitions). d. the expected effect that managing LTSS has on the utilization and unit costs of services. e. any effect that the management of this care is expected to have within each care setting and any effect in managing the level of care that the beneficiary receives (e.g., in-home care, community long-term care, nursing facility care).	N/A
ii. The projected non-benefit costs, such as administrative costs and care coordination costs, may differ for populations	N/A

Section II. Medicaid Managed Care Rates with Long-Term Services and Supports	
1. Managed Long-Term Services and Supports	
receiving MLTSS from other managed care programs, and the rate certification should describe how the projected non-benefit costs were developed for populations receiving these services.	
iii. The rate certification should provide information on historical experience, analysis, and other sources (e.g., studies or research) used to develop the assumptions used for rate setting.	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 plans in previous rating periods (i.e. starting in 2014, 2015, 2016, 2017, 2018, 2019 and/or January through June 2020), CMS expects the rate certification, as supported by assurances from the State, to describe: i. Any new data that is available for use in this rate setting.	N/A

Section III. New Adult Group Capitation Rates	Documentation Reference
1. Data	
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.	

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 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

Section III. New Adult Group Capitation Rates	Documentation Reference
2. Projected Benefit Costs	
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. 1. variations in the assumptions used to develop the projected benefit costs for covered populations must be based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations.	N/A

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

Section III. New Adult Group Capitation Rates	Documentation Reference
2. Projected Benefit Costs	
reimbursement rates or provider networks for the new adult group rates and other Medicaid population rates. d. Other material adjustments to the new adult group projected benefit costs.	
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 all Medicaid managed care rate certifications described in Section I of the guide, states must include in the rate certification submission and supporting documentation a description of the following issues related to the projected non-benefit costs for the new adult group: i. For states that covered the new adult group in Medicaid managed care plans in previous rating periods, any changes in data sources, assumptions, or methodologies used to develop projected non-benefit costs since the last rate certification. ii. How assumptions changed from the rate certification(s) for previous rating periods on the following issues: a. administrative costs.	N/A

Section III. New Adult Group Capitation Rates	Documentation Reference
3. Projected Non-Benefit Costs	
b. care coordination and care management. c. provision for operating or profit margin. d. taxes, fees, and assessments. e. other material non-benefit costs.	
B. The rate certification and supporting documentation must include information on key assumptions related to the new adult group and any differences between the assumptions for this population and the assumptions used to develop projected non-benefit costs for other Medicaid populations for the following issues: i. Administrative costs. ii. Care coordination and care management. iii. Provision for operating or profit margin. iv. Taxes, fees, and assessments. v. Other material non-benefit costs.	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	N/A

Section III. New Adult Group Capitation Rates	Documentation Reference
4. Final Certified Rates	
under 42 CFR §438.7(d)[12] that states that covered the new adult group in Medicaid managed care plans in previous rating periods provide: i. A comparison to the final certified rates or rate ranges in the previous rate certification. ii. A description of any other material changes to the capitation rates or the rate development process not otherwise addressed in the other sections of this guidance.	

Section III. New Adult Group Capitation Rates	Documentation Reference
5. Risk Mitigation Strategies	
A. CMS requests under 42 CFR §438.7(d) that states describe the risk mitigation strategy specific to the new adult group rates.	N/A
B. For states that covered the new adult group in Medicaid managed care plans in previous rating periods, CMS requests the following information: i. Any changes in the risk mitigation strategy from those used during previous rating periods.	N/A

[12] 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.

Section III. New Adult Group Capitation Rates	Documentation Reference
5. Risk Mitigation Strategies	
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.	