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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SMD # 23-005

RE: State Guidance on Claiming Methodologies for Medicaid Managed Care

August 10, 2023

Dear State Medicaid Director:

The purpose of this letter is to provide guidance on claiming Federal Financial Participation (FFP) for Medicaid managed care expenditures through capitation payments. In certain circumstances, a portion of a capitation payment should be matched with FFP at a "differential match rate" that varies from the standard Federal Medical Assistance Percentage (FMAP) for each state that is established in section 1905(b) of the Social Security Act (the Act). When claiming FFP at a differential match rate for a particular Medicaid benefit or beneficiary population (e.g., the 90 percent family planning match rate established at section 1903(a)(5) of the Act), states must develop a claiming methodology to identify the portion, or dollar amount, of the capitation rate attributable to each relevant benefit or population. The identified portion of the capitation rate should be applied to the capitation payment expenditures to calculate the amount of those expenditures that will be claimed on the Form CMS-64 at the differential match rate.

States must already ensure that its managed care expenditures are matched at the appropriate federal match rate, and CMS expects states to ensure that they have appropriate claiming methodologies in place by the quarter ending December 31, 2024. The Centers for Medicare & Medicaid Services (CMS) highly encourages states to develop claiming methodologies that include the guidelines specified in this guidance. If the benefit or population subject to a differential match rate is provided through multiple managed care programs, the state should develop a separate claiming methodology for each program as submitted on the quarterly Form CMS-64. Documentation should be maintained to support any claim for the differential match rate on the quarterly Form CMS-64. CMS may request the documentation as support for claims on the Form CMS-64 expenditure report, other financial reports and reviews, and audits.

Background

In general, states' expenditures for medical assistance are matched at the state-specific FMAP defined in the first sentence of section 1905(b) of the Act. The Act also specifies that certain expenditures are matched at an increased FMAP rate or a different federal match rate defined separately in statute. When a differential match rate is applicable to a portion of capitation payment expenditures for a particular Medicaid benefit or beneficiary population covered in a Medicaid managed care delivery system, states that meet all requirements applicable to the differential match rate may claim FFP for those expenditures at the differential match rate on the Form CMS-64, utilizing a claiming methodology. Examples of differential match rates include: family planning services, Indian Health Service facility services, services provided to certain beneficiaries with breast or cervical cancer, and community-based mobile crisis intervention services for which an enhanced rate is authorized by Section 9813 of the American Rescue Plan Act of 2021 (ARP).[1]

[1] This is not a comprehensive list. Claiming methodologies are required when states seek to claim the differential match rate applicable to a particular Medicaid benefit or population included within capitation rates paid to Medicaid managed care plans.

Claiming Methodology Development and Form CMS-64 Reporting

As outlined above, states must develop a claiming methodology to identify the portion of the capitation rate attributable to a particular benefit or population that is eligible at a differential match rate. This is necessary to ensure that states claim expenditures at the federal match rates as specified by statute. While states must already ensure that its managed care expenditures are matched at the appropriate federal match rate, CMS expects states to ensure that they have appropriate claiming methodologies in place by the quarter ending December 31, 2024. CMS believes this will allow states sufficient time to amend their current claiming practices and undertake any necessary procurement and contracting to support this work. As states develop claiming methodologies, CMS highly recommends that states do so consistent with the guidelines described below. CMS will not review and approve every claiming methodology. However, as outlined above, CMS may request documentation of a state claiming methodology as support for claims on the Form CMS-64 expenditure report or other audit. If states have questions or require technical assistance on this guidance, please contact CMS at: managedcareclaimingmethodologies@cms.hhs.gov.

Guidelines for Claiming Methodologies for Medicaid Managed Care

A claiming methodology that CMS would generally find reasonable addresses the components as described in the three steps below. Failure to include appropriate detail within a claiming methodology may result in additional CMS questions and/or data requests to assist in its review of the allowability and accuracy of related claims on the CMS-64. CMS has provided an example of a claiming methodology using these steps in the Appendix.

Step 1: Identify the managed care program that covers the particular benefit or population to which the differential match rate applies.

Information that a state should include in the methodology:

- Specify the particular benefit or population to which the differential match rate applies (e.g., family planning services, Indian Health Service facility services, community-based mobile crisis intervention services authorized by ARP Section 9813).
- Identify the managed care program and related state plan, waiver, or demonstration authority that covers the benefit or population to which the differential match rate applies. Provide the applicable state plan citation(s) and/or waiver or demonstration number(s) and name(s).

Step 2: Describe how key elements of the base data used to develop the capitation rates for the Form CMS-64 reporting period will be identified.[2] Include the following:

a. Types of data that will be used to identify the cost of the particular benefit or population subject to a differential match rate that were included in the base data used to develop the capitation rates for the Form CMS-64 reporting period. The following are examples of data fields that a state may consider:
    i. Healthcare Common Procedure Coding System (HCPCS)[3] and Current Procedural Terminology (CPT)[4] codes;

[2] The claiming methodology should be determined with the data utilized to develop the applicable capitation rates for the Form CMS-64 reporting period. This is outlined in guidance, SMD 21-003, SHO 21-008 and SHO 21-004.
[3] For a description of HCPCS codes see https://resdac.org/cms-data/variables/healthcare-common-procedure-coding-system-hcpcs-code-ffs.
[4] For information about CPT codes see https://www.ama-assn.org/amaone/cpt-current-procedural-terminology.

ii. Rendering Provider Type codes;[5] and
iii. Claim Place of Service codes.[6]

b. An assurance that the data and method used in the claiming methodology are consistent with the data and method used for development of capitation rates for the Form CMS-64 reporting period; approved state plan benefits, waivers, and demonstrations under which the applicable benefit or population are authorized; and any relevant guidance provided by CMS.

Information that a state should include in the methodology:

- Confirm that the data and method used for the claiming methodology are consistent with the data and method used to develop the capitation rates for the Form CMS-64 reporting period.
- Confirm whether an actuary involved in the development of the capitation rates was involved in developing or reviewing the claiming methodology.
- Describe the process used to identify the cost of the particular benefit or population subject to a differential match rate in the base data:
  - Confirm that the process used to identify the cost of the particular benefit or population subject to a differential match rate is consistent with approved state plan amendments, waivers, and demonstrations and any relevant guidance provided by CMS; for example, the process used to identify family planning services eligible for differential match rate.
  - Explain whether the particular benefit or population to which the differential match rate applies is a stand-alone category of service or rate cell in the rate development or had to be developed using a process consistent with the development of the capitation rates for the Form CMS-64 reporting period.
  - Specify the data fields or data field values used to identify the benefit or population to which the differential match rate applies in the base data; for example, HCPCS codes, Claim Place of Service Codes, and Rendering Provider Type Codes.

Step 3: Describe how the data identified in Step 2 will be used to calculate the portion of the capitation rates attributable to the particular benefit or population subject to a differential match rate (inclusive of non-benefit costs, as appropriate) for the Form CMS-64 reporting period.

a. Describe any material adjustment(s) applied to the base data for benefit costs (and non-benefit costs, as appropriate) in the rate development for the Form CMS-64 reporting period, including a rationale of why an adjustment for non-benefit costs is appropriate within the claiming methodology.
b. Describe any factors applied in determining the portion of the capitation rates attributable to the benefit or population subject to a differential match rate that are not directly represented in the base data used to develop the capitation rates for the Form CMS-64 reporting period.

[5] For a description of Rendering Provider Type codes, see https://resdac.org/cms-data/variables/servicing-provider-type-code.
[6] For a description of Claim Place of Service codes, see https://resdac.org/cms-data/variables/line-place-service-code-ffs.

Information that a state should include in the methodology:

- Describe each calculation step in the claiming methodology, in the order in which they will be taken, including clear descriptions of how the values resulting from any given step are linked to calculations in another step. The description of the steps may include the following:
    - Material adjustments, factors and trends applied.
    - The process used to determine non-benefit costs, as appropriate, and rationale of why an adjustment for non-benefit costs is appropriate within the claiming methodology.

Closing

States are encouraged to consult and review the example claiming methodology provided in the Appendix of this guidance as they develop and/or revise their claiming methodologies. States must already ensure that its managed care expenditures are matched at the appropriate federal match rate, and CMS expects states to ensure that they have appropriate claiming methodologies in place by the quarter ending December 31, 2024. Additionally, states must monitor their claiming methodology(ies) to ensure they continue to be appropriate and reasonable for their Medicaid managed care programs and to ensure that they claim FFP for Medicaid managed care expenditures at the applicable match rate specified by statute. If the state's monitoring indicates that a claiming methodology requires modification, the state should modify their methodology accordingly.

CMS remains committed to supporting states in appropriately claiming at differential match rates and is available to assist states as they develop claiming methodologies. For technical assistance, please contact CMS at managedcareclaimingmethodologies@cms.hhs.gov.

Sincerely,

/s/

Daniel Tsai
Deputy Administrator and Director

Appendix: Example State Claiming Methodology

Below is an example of a Medicaid managed care claiming methodology to claim a differential match rate. This is a general example and is not specific to any differential match rate.

Step 1	Identify the managed care program that covers the particular benefit or population to which the differential match rate applies.
Sample Response	This document describes the claiming methodology used to quantify the portion of the state's Medicaid managed care capitation rates subject to a differential match rate. This methodology applies to the Health First managed care program authorized under sections 1915(b) and 1932(a) authorities, entitled Health First 1915(b) waiver and First Choice 1932(a) state plan amendment, control numbers AB-1234 and AB 22-0001.
Step 2	Describe how key elements of the base data used to develop the capitation rates for the Form CMS-64 reporting period will be identified.
Sample Response	We identified the services subject to the differential match rate in the base data as a portion of the total base data used to develop the managed care plan (MCP) capitation rates. The data is maintained in the state's encounter data warehouse. In identifying these services, we used: • Level I and Level II HCPCS codes; • Provider Type Codes and Place of Service Codes that are consistent with the definition of the services subject to the differential match rate; and • The definition of the services subject to the differential match rate in the applicable State Plan Amendment (SPA) and/or waivers. The data and methods used to develop these elements are the same data and methods used to develop the state's MCP capitation rates for the Form CMS-64 reporting period. Actuaries involved in developing those capitation rates were also involved in developing and reviewing this methodology. We also consulted with the state's policy experts and data warehouse subject matter experts to ensure that we had identified the correct services.
Step 3	Describe how the data identified in Step 2 will be used to calculate the portion of the capitation rate(s) for the Form CMS-64 reporting period attributable to the particular benefit or population subject to a differential match rate (inclusive of non-benefit costs, as appropriate) for the Form CMS-64 reporting period.
Sample Response	The process we followed to determine the portion of the capitation rate follows the capitation rate development process: start with base data, apply trend factors, make adjustments to account for program changes, and account for non-benefit costs, as appropriate. The services subject to the differential match rate are maintained as a separate category of service throughout the rate development with its own adjustments and trends. In the rate development, separate non-benefit cost factors by category of service do not exist, so we applied the same non-benefit cost

	percentage to the projected services as were used for the aggregated rate cells of which such services are a component.