mhpa Medicaid Health Plans of America

May 26, 2021

Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: CMS-10398 (#37)/OMB control number: 0938-1148
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Medicaid and Children's Health Insurance Program (CHIP) Generic Information Collection Activities: Proposed Collection; Comment Request (CMS-10398 #37)

Dear Administrator Brooks-LaSure:

The Medicaid Health Plans of America (MHPA) is writing in response to your request for comment on the Notice published in the Federal Register on May 12th, 2021, related to the revision of the currently approved collection of information for the Medicaid Managed Care Rate Development Guide (the Guide). We believe the Guide is an important resource for states, Medicaid health plans, and stakeholders, and appreciate the opportunity to provide comments on "ways to enhance the quality, utility and clarity of the information to be collected."

MHPA represents the interests of the Medicaid managed care industry through advocacy and research to support innovative policy solutions that enhance the delivery of comprehensive, cost-effective, and quality health care for Medicaid enrollees. MHPA works on behalf of its 130+ member health plans, known as managed care organizations (MCOs), which serve more than 40 million Medicaid enrollees in 40 states, Washington, DC, and Puerto Rico. MHPA's members include both for-profit and non-profit, national and regional, as well as single-state health plans that compete in the Medicaid market.

The Guide is a valuable means for communicating essential information for states and their MCO partners that assist and support the Medicaid managed care rate-setting process in a transparent manner. We appreciate that the Guide provides detail around CMS' expectations of information to be included in actuarial rate certifications, acts as a basis for CMS' review, and builds upon the experience of states and CMS in completing rate certifications and review. We also recognize the explicit references to the statutory requirement for capitation rates to be actuarially sound (Section 1903(m) of the Social Security Act) and the implementing regulatory requirements at 42 CFR 438.4(b). However, we also believe that increased opportunities for engagement with Medicaid MCOs related to the development of the Guide prior to its official release on an annual basis, at a minimum, would help bolster efforts to incorporate and implement processes and actions that help ensure actuarial soundness and support transparency, clarity, and innovation in the Medicaid managed care rate development process. For example, we would be interested in working with CMS to develop requirements for including expenditures

for "social determinants of health" as quality improvement activities in Medical Loss Ratio calculations.

As we have shared previously with the agency (https://medicaidplans.org/wp-content/uploads/2020/07/MHPA-Letter-to-CMCS_9.20.pdf), MHPA believes that state adherence to two essential programmatic principles and safeguards, actuarial soundness and transparency protections, will support the continued financial viability of state partner Medicaid MCOs and help ensure the sustainability of the Medicaid program.

We have attached a table in the Appendix of this letter to address specific sections in the Guide and include recommendations for revisions in furtherance of actuarial soundness and transparency. The table includes a column for each recommended change that details the rationale for our suggested revisions. Please note that given the short timeframe to review the Guide and its accompanying materials with only a 14-day comment period, we have focused our comments on several key areas, but hope to continue an ongoing dialogue with CMS should other areas raise issues or questions to be addressed.

Thank you for the opportunity to provide feedback on the Guide. We believe the comment opportunity demonstrates your commitment to the principle of transparency and provides a pathway for stakeholder engagement that will ultimately benefit the Medicaid program and the beneficiaries we serve.

Please feel free to reach out to me directly at sattanasio@mhpa.org with any questions or should you need any additional information.

Sincerely,

Shannon Attanasio

Shannon Attanasio
Vice President, Government Relations and Advocacy

1575 Eye Street, NW Suite 300 Washington, D.C. 20005
TEL (202) 857-5720 FAX (202) 857-5731 www.medicaidplans.org

Appendix

Recommendations for revisions that apply across multiple sections and to specific sections are as follows (note: suggested changes made to Section I. should also be made to Section III. New Adult Group Capitation Rates of the Guide):

General Comments Applicable Cross-Sub-Sections	
Section I. Medicaid Managed Care Rates; Section B -Appropriate Documentation/Appendix	In Section B of Subsections 2 and 6 and as referenced in the Appendix, the Guide provides for the notation of actuary concerns with the risk adjustment process. We encourage CMS to consider adding an attestation and documentation provision for health plans who have participated in the rate setting conversation regarding areas of potential concern. We believe this would provide a formal path for Medicaid MCOs to highlight assumptions or reasonableness concerns that may result in program instability. We have included recommendations for potential processes for attestation and documentation in sections below.

Guide Section	2021-2022 DRAFT Guide Language	2021-2022 Suggested Guide Language	Rationale for Suggested Change
Section I. Medicaid Managed Care Rates; General Information			
I.1.A.ii. General Information-Rate Development Standards	Rate certifications must be done on a 12-month rating period.	Rate certifications must be done for a 12-month rating period. CMS will consider a time period other than 12 months to address unusual circumstances. For example, CMS would approve a time period other than 12 months 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).	Historically, CMS has allowed states flexibility in the length of the rating periods. These flexibilities have been used effectively by states to align contract years and RFP implementations. CMS should retain or clarify that alternative time periods for rating certification periods are available to support program alignment and implementation.
I.1.A.iii.(a) General Information – Rate Development Standards	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.	Add subsection (i) to the list: (i) include a statement that the 1.5% range is centered on the original capitation rates approved by CMS for that rating year.	It is important to clarify the point at which updated capitation rates require a revised rate certification. For example, if original capitation rates for a given region/rate cell are $100 PMPM and are adjusted to $98.6 PMPM, that reduction is 1.4%, and therefore would not require a revised rate certification. If another subsequent

1575 Eye Street, NW Suite 300 Washington, D.C. 20005
TEL (202) 857-5720 FAX (202) 857-5731 www.medicaidplans.org

			adjustment is made and the resulting capitation rate is $98 PMPM, relative to the original rate, it is a 2% reduction; relative to the first revised rate it is a 0.6% reduction. If a clarification is made that the range is centered on the original capitation rates, the second revision in the example above would require a revised rate certification. However, if the center point is reset each time the capitation rate changes, rates can continuously be adjusted well past 1.5% of the original rates and never require a revised rate certification. This scenario is extremely concerning and can put a state Medicaid program's health and stability at risk.
I.1.A.iii.(a) General Information – Rate Development Standards	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.	Add subsection (ii) to the list: (ii) include a statement that the actuary certifies the original rates plus any changes within 1.5% as actuarially sound.	This will support that any changes to the original capitation rates within 1.5% still result in an actuarial sound capitation rates. This is important since changes to capitation rates within 1.5% do not require a revised rate certification, so assurances on the front end that changes up to 1.5% will still result in actuarially sound rates is vital.
I.1.A.iii.(c)(vi) General Information – Rate Development Standards	If the actuary is certifying rates (not rate ranges) and the state and its actuary determine that a retroactive adjustment to the capitation rates is necessary, these retroactive adjustments must be certified by an actuary in a revised rate certification and submitted as a contract amendment in accordance with 42 CFR §438.7(c)(2). The revised rate certification must: … (A) - (B) …	Add (E) to the list: (E) demonstrate how the retroactive adjustment still maintains the projected (prospective) nature of capitation rate setting and allows MCOs to maintain efficiencies already achieved (e.g., updating the rates in alignment with ASOP 49 section 3.2.18, such as retroactively adjusting rates to correct specific assumption(s)).	It is important to maintain flexibility that allows retroactive rate adjustments when a specific assumption (or a few specific assumptions) are materially incorrect. However, making a retroactive rate adjustment should not remove the prospective nature of capitation rate setting. Removing the prospective nature of capitation rate setting is effectively a program wide risk-sharing mechanism, which 42 CFR 438.6(b)(1) states cannot be changed retroactively. Doing so can harm the health and stability of the program and ultimately the beneficiaries.

			Additionally, efficiencies will ultimately be captured in the capitation rates as that data is used as base data in subsequent rate development.
I.1.A.iv. General Information – Rate Development Standards	Any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations must be based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations. Any differences in the assumptions, methodologies, or factors used to develop capitation rates must not vary with the rate of Federal financial participation (FFP) associated with the covered populations in a manner that increases Federal costs. The determination that differences in the assumptions, methodologies, or factors used to develop capitation rates for MCOs, PIHPs, and PAHPs increase Federal costs and vary with the rate of FFP associated with the covered populations must be evaluated for the entire managed care program and include all managed care contracts for all covered populations.	N/A	This section includes a requirement to evaluate for differences for the entire managed care program and include all managed care contracts for all covered populations to ensure cap rates must not vary with the rate of FFP. We would like to take this opportunity to note that there are verifiably different rating factors at play among populations – particularly in the case of expansion populations. State contract requirements pertaining to the population (e.g., jail transitions, housing supports, employment support) in addition to churn, relatively newness to Medicaid, and managed care and pent-up demand, all result in variables that may factor into distinct rate cell differences.
I.1.A.vii. General Information – Rate Development Standards	… Capitation rates must be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio, as calculated under 42 C.F.R. § 438.8, of at least 85 percent for the rate year. The capitation rates may be developed in such a way that	Add the following sentence after this sentence: The actuary should include a projection of the estimated pre-tax net income for the capitation rate year to support the capitation rates are adequate for reasonable,	The inclusion of an expected pre-tax net income will allow CMS and the health plans to review this assumption, in conjunction with other assumptions, to determine if capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs.

1575 Eye Street, NW Suite 300 Washington, D.C. 20005
TEL (202) 857-5720 FAX (202) 857-5731 www.medicaidplans.org

	the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard greater than 85 percent, as calculated under 42 C.F.R. § 438.8, as long as the capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs.	appropriate, and attainable non-benefit costs.	
I.1.A.xiii. General Information – Rate Development Standards	Procedures for rate certifications for rate and contract amendments, include: … (a) – (f) …	Add (g) to the list: Any rate certification and supporting documentation provided to CMS on the capitation rate development must be provided by the state to each MCO, PIHP or PAHP within 5 federal business days of submission to CMS.	The level of detail for the information shared from states and their actuaries to MCOs can vary greatly from state to state. MCOs receiving the same level of information and detail that CMS receives will support transparency in the rate development process and provide the opportunity for more meaningful discussions around actuarial soundness concerns. Additionally, this level of information provided is more robust than what would be posted to the website if the state and their actuaries chose to certify a rate range. Per ASOP 41, since the MCOs are "intended users" of the rates, MCOs should receive the same Actuarial Report that CMS receives.
I.1.B.ii. General Information – Appropriate Documentation	States and their actuaries must document all the elements described within their rate certification to provide adequate detail such 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 documentation as necessary to review and approve the rates. States and their actuaries must ensure	Add (d) to the list: (d) A summary outlining what information was shared with MCOs, indicating if it was the same information shared with CMS. If not, exhibits and rate narratives provided to the MCOs that were used to communicate the development and results of the capitation rates, should be provided to CMS.	Documentation allows CMS to see what information is provided to MCOs (and to determine if any information differs).

1575 Eye Street, NW Suite 300 Washington, D.C. 20005
TEL (202) 857-5720 FAX (202) 857-5731 www.medicaidplans.org

	that the following elements are properly documented: … (a) – (c) …		
I.1.B.xi – **NEW** General Information – Appropriate Documentation	N/A	xi. Within 14 federal business days following a state submission to MCOs, PIHPs or PAHPs the rate certification and documentation of the capitation rate development, the MCOs, PIHPs, PAHPs or the Health Plan Association may submit page limited feedback regarding top actuarial soundness concerns of the capitation rates directly to the state and that information will forward to CMS by the state via email inbox. Feedback should include contact information for the MCO, PIHP, PAHP or Health Plan Association for follow-up questions as needed.	This supports transparency in the rate development process. Even if the recommendation for adding in section I.1.A.xiii. is taken, this provides the MCOs/Association an opportunity to share any concerns with actuarial soundness to CMS and maintaining state engagement in the process. This is an important communication avenue since certain actuarial soundness concerns may come to light once final capitation rates are received by the MCOs. This can help CMS identify areas of interest that may require additional review prior to their final approval of determining if rates are actuarially sound and can be used to cross check against the information sent by the state.
Section I. Medicaid Managed Care Rates; Data			
I.2.A.i.(b) Data – Rate Development Standards	(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.	Replace (b) with the following: (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 rates. *Due to the impacts of the COVID-19 Public Health Emergency (PHE) on service patterns and utilization, states and their actuaries may continue to use pre-PHE data as base data, even if it is not in the three most recent and complete years prior to the rating period. If states and*	Given the disruption the COVID-19 PHE caused in the healthcare system, it is important to provide flexibilities when selecting appropriate base data. To the extent the most appropriate base data is from a pre-PHE time period and it is more than three years from the rating period, flexibilities should exist to allow the selection that base data given the unprecedented nature of the COVID-19 PHE. If base data that is impacted by the COVID-19 PHE is selected, it is important for the states and their actuaries to provide rationale for why the time period was selected and the methodology/assumptions used to adjust the data as COVID-19 PHE impacts may not be fully known.

1575 Eye Street, NW Suite 300 Washington, D.C. 20005
TEL (202) 857-5720 FAX (202) 857-5731 www.medicaidplans.org

		their actuaries use data impacted by the COVID-19 PHE to develop base experience, the rationale for why this period was chosen and the assumptions, methodologies and impacts of the adjustments made to the base data must be included in the rate certification.	
I.2.B.ii.(a).(ii) Data – Appropriate Documentation	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:…(i) – (iv) (ii) the age or time periods of all data used.	Replace (ii) with the following: (ii) the age or time periods of all the data used *and a description of what the data was used for (e.g., create a programmatic adjustment factor) and how it was used (e.g., applied to projected benefit costs after application of trend).*	Describing what the data was used for and how it was used will increase transparency in the rate development process. For example, if the entirety of actual program experience in a rating year was used to retroactively overwrite the previously prospectively developed capitation rates, it is important for that to be clearly communicated in the rate certification documentation.
Section I. Medicaid Managed Care Rates; Special Contract Provisions Related to Payment			
I.4.B.i. Special Contract Provisions Related to Payment – Withhold Arrangements	Rate Development Standards … (a) – (b) …	Add (c) to the list as follows: (c) if withhold measures change materially after the submission of the rate certification or if the measures remain undefined at the time the rate certification is submitted, the state and their actuaries must disclose this fact and redetermine if the withhold measures remain reasonably achievable once defined and finalized.	Understanding the withhold measures and their thresholds for payment on a prospective basis is vital for MCOs. It provides the opportunity for planning to have success achieving the withhold measures. It is not uncommon for withhold measures to be updated materially after the start of the rating period or that they remain undefined at the start of the rating period. Without the opportunity to plan for the withhold measures, achievability must be redetermined to ensure the capitation rates remain actuarially sound. We believe more stringent requirements on the state Medicaid programs regarding including quality withhold arrangements that are built into rates would address the lack of structure in some states related to the quality withhold portion of the rate

1575 Eye Street, NW Suite 300 Washington, D.C. 20005
TEL (202) 857-5720 FAX (202) 857-5731 www.medicaidplans.org

			development. The CMS 2020-2021 Medicaid Managed Care Rate Development Guide, the 2021-2022 Medicaid Managed Care Rate Development Guide, 42 CFR 438.6, and ASOP 49 all address the importance of the quality withhold adjustment. . For example, in some states, we are not aware of the parameters until well into the year creating challenges for being able to earn back the withheld dollars. Accordingly, in our review of withhold applications in practice, we have identified a number of areas where the current regulatory text language allows for improvement. Specifically, we have the following suggested additions to the current requirements: 1) The quality withhold can be a material portion of the revenue at risk for the plans, especially when compared to the level of underwriting gain included in the capitation rates. The assumption on achievability is a critical component of rate setting. Therefore, the criteria for earning back the entire withhold should be clearly defined in the rate certification. 2) The health plans require time to prepare and implement strategies to meet the quality criteria and earn the withheld amount. The criteria for earning back the entire withhold should be made known to the health plans prior to the evaluation period. 3) We have observed instances where the quality withhold criteria is adjusted throughout the rating period. These adjustments impact the achievability of earning the withhold. The certifying actuary should clearly indicate what percent of the withhold is considered reasonably achievable

1575 Eye Street, NW Suite 300 Washington, D.C. 20005
TEL (202) 857-5720 FAX (202) 857-5731 www.medicaidplans.org

			in the development of the rates, and 4) The certifying actuary must indicate what percent of achievability would result in the rates becoming unsound.
I.4.B.ii.(a) Special Contract Provisions Related to Payment – Withhold Arrangements	the rate certification must include a description of the withhold arrangement. An adequate description includes at least the following: … (i) – (vii) …	Add (viii) to the list as follows: (viii) the rationale for why the measures/metrics were chosen and why/how the thresholds for payment were chosen.	The level of detail provided by states and their actuaries on withhold arrangements varies significantly. Providing rationale for the measures/metrics chosen and why/how the thresholds for payment will assist CMS in understanding the intent/goal of the withhold arrangement and increase transparency in the rate development process.
I.4.C.ii.(a).(iv) Special Contract Provisions Related to Payment – Risk-Sharing Mechanisms	(iv) documentation demonstrating that the risk-sharing mechanism has been developed in accordance with generally accepted actuarial principles and practices.	Replace (iv) with the following: (iv) documentation demonstrating that the risk-sharing mechanism has been developed in accordance with generally accepted actuarial principles and practices, *including but not limited to, development of the funding pool, rationale for the center point of the arrangement, the width of risk-sharing bands, if they are symmetric and the percent of risk shared at each band.*	It is not always clear that risk-sharing mechanisms are developed in accordance with generally accepted actuarial principles and practices. Providing examples of what should be included in the documentation will set more clear expectations of what should be considered and described when demonstrating that risk-sharing mechanisms are developed in accordance with generally accepted actuarial principles and practices. We also believe that there are opportunities for the development of parameters to better inform the use of risk sharing mechanisms by state Medicaid managed care programs and to ensure that these tools are used appropriately; we would invite future discussions with the agency for this purpose.
I.4.C.ii.(a) Special Contract Provisions Related to Payment –	the rate certification and supporting documentation must include a description of any other risk-sharing arrangements.,. An adequate description of these includes	Add (v) to the list: (v) the methodology used to calculate the risk-sharing arrangement result	This will align the documentation required to support the risk-sharing arrangement with the documentation required to support minimum MLR arrangements with remittances.

1575 Eye Street, NW Suite 300 Washington, D.C. 20005
TEL (202) 857-5720 FAX (202) 857-5731 www.medicaidplans.org

Risk-Sharing Mechanisms	at least the following: … (i) – (iv) …		
I.4.C.ii.(a) Special Contract Provisions Related to Payment – Risk-Sharing Mechanisms	the rate certification and supporting documentation must include a description of any other risk-sharing arrangements. An adequate description of these includes at least the following: … (i) – (iv) …	Add (vi) to the list: (vi) the formula for calculating a remittance/payment for having a risk-sharing result below/above the predetermined thresholds.	This will align the documentation required to support the risk-sharing arrangement with the documentation required to support minimum MLR arrangements with remittances. It will also provide clarity to CMS how the calculation of the risk-sharing mechanism works.
I.4.C.ii.(a) Special Contract Provisions Related to Payment – Risk-Sharing Mechanisms	the rate certification and supporting documentation must include a description of any other risk-sharing arrangements. An adequate description of these includes at least the following: … (i) – (iv) …	Add (vii) to the list: (vii) any other consequences for a remittance/payment for a risk-sharing result below/above the predetermined thresholds.	This will align the documentation required to support the risk-sharing arrangement with the documentation required to support minimum MLR arrangements with remittances.
Section I. Medicaid Managed Care Rates; Projected Non-Benefit Costs			
I.5.B.i Projected Non-Benefit Costs – Appropriate Documentation	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) – (c) …	Add (d) to the list: (d) A description of the statistically-based model and assumptions used to develop the Underwriting Gain assumption; including the two major components of cost of capital and risk margin.	Medicaid managed care is unique from other health insurance in that the entity setting the capitation rates is not usually the entity bearing the risk of mispricing. Since the rate-setting actuaries do not bear the financial risk of mispricing, they do not have the same economic incentive to include margins for deviation as does a pricing actuary working in other lines of health insurance. Since Medicaid MCOs rely on the state's actuary to develop capitation rates at levels that adequately fund the program, even in years of adverse deviation, explicit inclusion of an adequate risk margin in the capitation rates is especially important. Another unique aspect of Medicaid capitation rate setting is that the state actuary often develops rates for the program overall, rather than for each specific MCO, using the combined experience of all MCOs in the program.

1575 Eye Street, NW Suite 300 Washington, D.C. 20005
TEL (202) 857-5720 FAX (202) 857-5731 www.medicaidplans.org

			This further increases the risk that the rates for any one MCO within the program may not be adequate. Not only will actual results vary from expected results for the entire Medicaid program, but results will vary by each individual MCO. Some of the variation is due to factors that generally exist across all types of health insurance and are outside the MCOs' control, such as anti-selection or the inability of risk-adjustment mechanisms to fully capture membership risk, which further supports the need to include risk margin.
I.5.B.i Projected Non-Benefit Costs – Appropriate Documentation	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) – (c) …	Add (e) to the list: (e) a disclosure of the portion of the administrative expenses related to activities that improve healthcare quality and the portion of the administrative expenses not related to activities that improve healthcare quality.	This will help illustrate how much of each type of administrative expense is loaded into the capitation rates, which can be used to ensure a reasonable load is added for each component.
I.5.B.ii Projected Non-Benefit Costs – Appropriate Documentation	States and actuaries should estimate the non-benefit costs for each of the following categories of costs: (a) Administrative costs. (b) Taxes, licensing and regulatory fees, and other assessments and fees (c) Contribution to reserves, risk margin, and cost of capital	Replace (c) with the following: (c) *Underwriting gain assumptions*, including cost of capital, contributions to reserves, and risk margin *including the impact of contractual requirements such as minimum MLRs, performance withholds and incentives that impact the underwriting gain.*	Medicaid programs have changed such that there are now common limitations in Medicaid contracts (e.g., risk sharing and withholds) which cause the amount of underwriting gain in the rates to not result in the MCO percentage of net income. Therefore, a more precise analysis is required to determine an appropriate underwriting gain assumption.

1575 Eye Street, NW Suite 300 Washington, D.C. 20005
TEL (202) 857-5720 FAX (202) 857-5731 www.medicaidplans.org

<table>
<tr><td></td><td>(d) Other operational costs associated with the provision of services identified in § 438.3(c)(1)(ii) to the populations covered under the contract.</td><td></td><td></td></tr>
<tr><td colspan="4">Section II. Medicaid Managed Care Rates with Long-Term Services and Supports</td></tr>
<tr><td>II.1.C.i.(c)

Managed Long-Term Services and Supports – Appropriate Documentation</td><td>(c) any other payment structures, incentives, or disincentives used to pay the MCOs, PIHPs or PAHPs (for example, states may provide additional payments to managed care plan(s) that transition beneficiaries from institutional long-term care settings into other settings, or may pay adjusted rates during time periods of setting transitions).</td><td>Replace (c) with the following:

(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). This must include comments on how these payment structures were developed and their achievability (e.g., if using a blended rate with a HCBS transition assumption, how was the transition assumption developed and how does it align with historical beneficiary placement trends and account for market specific conditions).</td><td>It is not always clear how certain payment structures are developed and if their achievability was considered.

This becomes even more important as the temporary FMAP increase is in place for HCBS services. It is vital that the states and their actuaries develop reasonable and achievable assumptions around these payment structures.</td></tr>
<tr><td colspan="4">Appendix A</td></tr>
<tr><td>Appendix A, Introduction</td><td>Under the accelerated rate review process, for certifications that meet qualifying criteria , states must submit the following:</td><td>Replace (2) with the following:

(2) the full rate certification and related supporting documents, including MCO</td><td>Including the actuarial soundness concerns that MCOs or Health Plan Associations have will increase transparency and provide CMS another perspective if an accelerated rate review is appropriate.</td></tr>
</table>

1575 Eye Street, NW Suite 300 Washington, D.C. 20005
TEL (202) 857-5720 FAX (202) 857-5731 www.medicaidplans.org

	(1) the Rate Development Summary, (2) the full rate certification and related supporting documents, and (3) the executed managed care plan contracts for the certified rates.	*or Health Plan Association actuarial soundness concerns*, and	
Appendix A, Criteria for a Rate Certification to Qualify for Accelerated Rate Review #6	6. No material issues have been identified (by any party) in rate setting for the prior rating period. Material issues are generally identified through extensive questioning or conference calls. CMS retains discretion to determine whether or not material issues were identified in rate setting for the prior rating period; therefore, states should give CMS prior notice if they intend to participate in the accelerated rate review.	Replace 6 with the following: 6. No material issues have been identified (by any party, *including MCOs or Health Plan Associations*) in rate setting for the prior rating period. CMS retains discretion to determine whether or not there were material issues that were identified in rate setting during the prior rating period, and therefore states should give CMS *and MCOs or Health Plan Associations* prior notice if their intention is to participate in the accelerated rate review. Material issues are generally discussed through extensive questioning or conference calls.	Ensuring that MCOs are included in the definition of "any party" will clarify which entities can identify material issues and help CMS truly understand what are the material issues. This highlights the importance for an avenue for MCOs or the Associations to submit top actuarial soundness concerns in writing to CMS shortly after the rate certification documentation is submitted for CMS review.

1575 Eye Street, NW Suite 300 Washington, D.C. 20005
TEL (202) 857-5720 FAX (202) 857-5731 www.medicaidplans.org