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Ms. Amy Gentile
Mr. William N. Parham, III
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Centers for Medicare and Medicaid Services
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Via electronic mail to www.regulations.gov

Re: CMS-10398 (#37) / OMB control number: 0938-1148

Dear Ms. Gentile and Mr. Parham:

Medicaid is an essential part of American health care, and health insurance providers are committed to ensuring Medicaid is effective, affordable, and accountable. With that commitment in mind, America's Health Insurance Plans (AHIP) and its member Medicaid health plans appreciate the opportunity to provide comments on the *2021-2022 Medicaid Managed Care Rate Development Guide* (the "Guide").

In 39 states, Washington DC, and Puerto Rico, Medicaid programs contract with Medicaid managed care organizations (MCOs) to serve their enrollees. Nationwide, Medicaid MCOs enroll and serve more than 55 million people, about two-thirds of all Medicaid enrollees. Although states manage Medicaid eligibility and enrollment, Medicaid MCOs manage a full range of other functions for states and provide a variety of services to meet the unique needs of Medicaid enrollees. MCOs implement programs that coordinate and improve care and health outcomes; offer services that promote prevention and healthy living and connect enrollees with non-medical supports, such as social services or transportation; and carry out functions that include customer service, claims processing, reporting, and program integrity. Medicaid MCOs improve quality for enrollees and achieve cost savings for states and the federal government. Medicaid MCO enrollees are more likely to receive preventive services, have fewer hospital admissions, and better access to primary care than enrollees in fee-for-service programs.

The Social Security Act requires that states contracting with MCOs establish actuarially sound rates, and that CMS review and approves such rates. This process is critically important. It ensures that federal funds are used efficiently, and that Medicaid MCOs have adequate resources to ensure providers are accessible and can deliver all contracted services to the low income and vulnerable populations they serve.

We appreciate that the draft 2021-2022 Guide includes additional references that reinforce the requirement for actuarial soundness in multiple areas of discussion, such as rate development standards, rate ranges, and withholds. Updated each year, the Guide is a key resource for state Medicaid programs and Medicaid MCOs in ensuring the actuarial soundness of rates. The 2021-2022 version of the Guide takes on added importance, given the impacts of the COVID-19 public health emergency (PHE) on Medicaid programs, state governments and providers, as well as the federal and state responses to those impacts. Those impacts have included a variety of statutory and regulatory changes, plus new rate setting flexibilities and other guidance for states that directly impact actuarial soundness.

We believe the 2021-2022 Guide requires further modification to incorporate all the disparate pieces of guidance documents into a coordinated package that provides necessary clarity on federal rate-setting standards in Medicaid. We also urge CMS to update the Guide to implement certain other changes in its rate review process to reflect the ongoing actuarial uncertainties caused by the pandemic and improve the overall process of developing rates. The remainder of this letter presents our comments and recommendations on these key issues; a separate Appendix presents suggestions on certain technical issues for consideration.

1. **Withdraw or Delay Accelerated Rate Review.** The 2021-2022 Guide includes the Accelerated Rate Review process introduced in 2020. The accelerated review process allows states to submit a Rate Development Summary to CMS with significantly less detail than the full rate certification package. CMS can determine whether rates are actuarially sound based primarily on information in the Rate Development Summary.

   We had serious concerns with the Accelerated Rate Review process when it was announced in the 2020-2021 Guide, without the benefit to stakeholders of a formal notice and comment rulemaking process. We believe the Accelerated Rate Review process does not meet CMS' statutory obligation to oversee and ensure state rates are actuarially sound. Our concerns are now magnified given the significant impacts of the ongoing PHE on patterns of care and costs. Traditional comprehensive reviews of full rate certifications and documentation clearly remain necessary. We urge CMS to withdraw this process in its entirety and exclude it from the final 2021-2022 Guide.

2. **Accounting for Effects of COVID on Base Period Data.** As noted above, the PHE has created an unprecedented degree of actuarial uncertainty with respect to the magnitude and timing of service utilization and costs. Utilization patterns changed significantly in the second quarter of 2020 as a result of stay-at-home orders and deferred care. Even as some patterns of care have returned to normal in 2021, there may be more sustained shifts in certain patterns of utilization, e.g., in emergency room care, telehealth, and behavioral health services. Congress has responded with new Medicaid options in the *American Recue Plan Act,* including extension of Medicaid coverage for postpartum women, and enhanced FMAP for crisis intervention services and home and community-based services. States have responded with directed payments and changes to rates and risk mitigation measures. In

addition, the resumption of state eligibility redeterminations following the termination of the PHE will further alter the overall case mix and risk profile of Medicaid enrollees.

The PHE is a sustained, unprecedented event that has resulted in significant anomalies in 2020 and 2021 cost and utilization data. Any given state's capitation rates and risk mitigation programs that are developed using the PHE-impacted data as a base period will require material changes in assumptions and adjustments, e.g. to normalize for the PHE impacts.

In the draft Guide, CMS states its expectation that actuaries will account for direct and indirect impacts of the PHE on capitation rates through evaluation of relevant data; and recommends implementation of 2-sided risk mitigation strategies for rating periods impacted by the PHE. We believe that CMS should go further and provide more detailed, specific requirements and expectations as to how actuaries should account for COVID-19 impacts so as to avoid actuaries reaching different conclusions based on individual judgment and interpretation.

We strongly recommend that CMS devote a section of the Guide to discussion of the impacts of the PHE on costs and utilization and guidance regarding CMS expectations for how states and actuaries should account for those extraordinary impacts on trends and projections. In addition, CMS should allow flexibility to use a base period that is not in the three most recent and complete years prior to the rating period if appropriate for a given program, with appropriate additional documentation (e.g., methodologies and assumptions used to normalize the data, etc.). And if a state chooses a PHE-impacted period to develop base experience or for programmatic change adjustments or prospective adjustments, CMS should require a justification and additional detailed documentation.

3. **Connect Rate Development Issues with Related Guidance.** Since the onset of the PHE and release of the 2020-2021 version of the Guide, CMS has issued significant guidance with implications for Medicaid rate development, including:

    a. *Implementation of American Rescue Plan Act of 2021 Section 9817: Additional Support for Medicaid Home and Community-Based Services during the COVID-19 Emergency.* State Medicaid Director Letter dated May 13, 2021.

    b. *Additional Guidance on State Directed Payments in Medicaid Managed Care.* State Medicaid Director Letter dated January 8, 2021.

    c. *Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency.* State Health Official Letter dated December 22, 2020.

    d. *Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care (CMS–2408–F).* Final rule dated November 13, 2020.

    e. *Value-Based Care Opportunities in Medicaid.* State Medicaid Director Letter dated September 15, 2020.

f. *Medicaid Managed Care Options in Responding to COVID-19.* CMCS Informational Bulletin dated May 14, 2020.

The draft Guide discusses some of the topics raised in these guidance documents, but we believe states and actuaries would benefit from a more concerted discussion of their relevance to rates. We recommend that CMS expand the Guide so that it provides a comprehensive reference for states, actuaries, Medicaid MCOs, and other stakeholders addressing all the relevant guidance and their impacts on rate setting standards.

4. **Clarify the Use of Minimum Medical Loss Ratio (MLR) Requirements in Rate Setting.** The draft Guide lacks clear guidance on two important issues relating to the calculation of medical loss ratios (MLRs) for purposes of setting rates.

   a. Operational costs. Under 42 C.F.R. § 438.4(a), actuarially sound capitation rates are "projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract *and for the operation of the MCO, PIHP, or PAHP* for the time period and the population covered under the terms of the contract." In § 438.4(b)(9), the regulations further clarify that capitation rates need to be developed to achieve a minimum MLR that provides for "reasonable, appropriate, and attainable *non-benefit* costs." The 2021-2022 Guide mentions these regulatory requirements, but we believe it needs to further emphasize and clarify for states that actuarial soundness requires adequate coverage of non-benefit costs (e.g., administrative costs, quality improvement activities, and underwriting gain) many aspects of which are required by state contracts and federal regulations.

   b. SDOH. CMS, states, and Medicaid MCOs have increasingly taken steps to address impacts of social barriers and social determinants of health (SDOH) on the health status and outcomes of Medicaid enrollees. States like North Carolina are building SDOH identification and mitigation strategies into their Medicaid managed care programs. MCOs have been working with community organizations and offering value-added benefits to meet the social needs of their enrollees, focusing on issues such as food insecurity, physical activity, transportation, and housing. We urge CMS to update the Guide to address requirements and conditions for including these expenditures as quality improvement activities in capitation rates and minimum MLR remittance calculations. Recognition of such expenditures in MLR calculations will encourage greater investments in services that reduce health disparities and promote health equity, improve the overall health of Medicaid enrollees, and reduce long-term program costs for federal and state payers.

5. **Provide Detailed Guidance on Quality Withhold Arrangements.** The Guide, 42 CFR 438.6, and Actuarial Standard of Practice (ASOP) 49 all address the use of quality withhold adjustments in Medicaid managed care. However, we have concerns about the transparency and timeliness of processes in some states incorporating quality withholds into Medicaid rate development. AHIP members have identified a number of areas where CMS standards are

needed to ensure that states meet federal regulatory requirements concerning withhold arrangements, including that withholds must be reasonable and capitation payments minus withholds that are not reasonably achievable cannot be considered actuarially sound. Specifically, we recommend the Guide address the following topics:

a. Clearly defined criteria. Quality withholds can be a material portion of MCO payments, especially with respect to the level of underwriting gain assumed in capitation rates. Assumptions regarding the achievability of the related quality performance metrics are a critical component of rate setting. The Guide requires that the rate certification include a description of the withhold arrangement, and that the capitation payment minus any withheld portion that may not be reasonably achievable must be actuarially sound. However, we believe the Guide needs to more directly specify that criteria for earning the entire withhold must be clearly defined in the state's rate certification. In addition, the Guide should also address the level of detail needed to establish that withholds or percentages thereof are reasonably achievable. We are concerned that state assumptions may overestimate achievability or be inaccurate or unreasonable and therefore jeopardize overall actuarial soundness.

b. Advance notice. MCOs require time to prepare and implement strategies to meet state performance expectations as defined in the quality criteria. For example, in some states, MCOs are not informed of the quality withhold parameters until well into the rating year, which limits their ability to address the state's priority performance expectations. In addition, depending on the metric, there can be significant lag times between the measurement year and the reporting year. The Guide should specify that criteria for performance and earning the amounts withheld should be communicated to MCOs prior to the beginning of the performance evaluation period.

c. Mid-year changes. We are aware of instances in which the quality withhold criteria are adjusted during the rating period. Such adjustments impact the achievability of meeting quality metrics and earning withheld funds. Ideally, changes in performance metrics relating to quality withholds should be applied only on a prospective basis. But if such changes are deemed appropriate on review, the Guide should require the certifying actuary to clearly describe how such adjustments impact the achievability of earning the withhold and the overall effects on actuarial soundness and rate adequacy.

6. **Add More Clarity in Standards for Risk Sharing Mechanisms.** As the PHE unfolded last year, states responded in part with a range of new risk sharing mechanisms and modifications of existing arrangements. From that experience, we believe there is a need for CMS to provide additional guidance and structure for state risk sharing mechanisms to ensure the appropriate use of risk sharing tools. Specifically, we recommend that CMS expand the discussion of risk-sharing mechanisms to provide guidance on the criteria or market conditions to be considered when states deploy risk sharing mechanisms, such as risk corridors and reinsurance programs.

In addition, given the significant activity in Medicaid risk sharing mechanisms over the past year, we urge CMS to convene a technical expert panel (TEP) to develop consensus standards for key elements of risk sharing mechanisms, such as: calculation of uncertainty in prospective rate setting, optimal width and symmetry of risk corridor bands, formulae for calculating MCO obligations, and use of federal MLR definitions in risk corridors. The TEP should include representatives from CMS, state Medicaid programs, consulting actuaries, MCO actuaries, and the American Academy of Actuaries and Society of Actuaries.

7. **Encourage Best Practices that Include MCOs in the Rate Development Process.** As noted above, Medicaid MCOs now serve nearly two-thirds of Medicaid enrollees in 40 Medicaid programs. They provide the operational infrastructure and expertise that engages and connects members with care, coordinates care among providers, administers funding to providers, and reports on the results of operations to states. MCOs also have significant insights into how Medicaid programs are functioning at the local level, what's working, and what's not.

   Despite these facts, states are quite variable in their levels of engagement and consultation with MCOs for a variety of reasons, including competing priorities, staffing resources and levels of experience. This variability in engagement and consultation extends to rate setting as well. Some states are very transparent in their communications with MCOs on base data, assumptions, and calculations, and solicit MCO input so that resulting proposed rates have been generally vetted prior to submission to CMS. Other states have much less transparency and communication.

   We believe that stakeholders involved with the Medicaid program, including CMS actuaries reviewing state rate submissions, are best served when states and MCOs engage and consult openly on rate issues. We strongly urge CMS to expand the Guide to highlight best practices and convey its expectation to states that they engage and consult more directly with MCOs in developing rates. Such standards would support the long-term interest of states, the federal government, and Medicaid enrollees, and would ultimately reduce the resources and time required to complete rate reviews. Consistent with this recommendation, we offer some specific suggestions for consideration in the Appendix. These are presented as suggested revisions and addition to the text of the draft Guide.

   Similarly going forward, we strongly encourage CMS to circulate the draft Guide each year for review and comment by stakeholders with at least a 30-day comment period, given the significance of Medicaid rate setting and the extent of changes. Beyond providing stakeholders with an opportunity to provide feedback, such a process would be beneficial to identifying areas for clarification and highlighting guidance applicable to emerging trends or state-specific circumstances.

8. **Reinvigorate CMS Oversight of Federal Investments in Medicaid.** The standard federal medical assistance percentage (FMAP) ranges from 50% to as high as 78% of a state's

Medicaid costs; and in states that expanded Medicaid, FMAP is 90% for expansion enrollees. On average, the federal government pays over two-thirds of the cost of Medicaid. Accordingly, CMS has a compelling interest in overseeing and ensuring the effectiveness and integrity of federal investments in the Medicaid program.

Despite this clear federal interest, we are concerned with the perception that has evolved over a number of years that CMS increasingly views Medicaid capitation rates as primarily a contractual matter between states and Medicaid MCOs, and thereby prefers a more hands-off approach to rate review. The Accelerated Rate Review process discussed above is one of the latest examples of this approach. We believe this perspective is inconsistent with CMS' obligations under the Social Security Act to ensure rates are actuarially sound. We are also concerned, as a practical matter, that limited oversight fails to recognize that many states lack the national perspective, actuarial expertise, and analytical resources available to CMS. Accordingly, we urge CMS to ensure that the Guide, other CMS guidance, and the agency's internal processes all clearly support CMS' active role in assessing, validating, and confirming the components of state rate proposals – data, assumptions, calculations, and projections. Any other approach fails to safeguard the substantial federal investments in Medicaid, adversely affects enrollees and providers, and can jeopardize the program's long-term viability.

Thank you again for the opportunity to comment on the Rate Development Guide and for your attention to our concerns and consideration of our recommendations. AHIP is committed to continuing a strong working relationship with CMS to ensure the long-term viability and effectiveness of the Medicaid program for the people it serves and the state and federal taxpayers who pay for it. Please let us know if you have any questions. We would welcome the opportunity to discuss in more detail.

Sincerely,

Rhys W. Jones, MPH
Vice President, Medicaid Policy and Advocacy

Cc: Anne Marie Costello, CMCS

Appendix: Specific Recommendations on the Draft Guide

In this appendix, we offer specific technical comments and policy recommendations on the draft Guide for consideration by CMS.

1-A. General Information – Rate Development Standards		
Guide Section	**Suggested Revision/Addition**	**Rationale**
Section 1.A.iii. (a)	Add under A-iii (a): (i) include a statement that the 1.5% range is centered on the original capitation rates approved by CMS for that rating year. (ii) include a statement that the actuary certifies the original rates plus any changes within 1.5% as actuarially sound.	The Guide should clarify at what point updated capitation rates would require a revised rate certification, e.g. in the case of a later rate change; and that any changes to the original capitation rates within 1.5% would still result in actuarially sound rates.
Section 1.A.iii. (c).(vi)	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 negate the prospective nature of capitation rate setting.
Section 1.A.vii.	Add the following sentence: The actuary should include a projection of the estimated pre-tax net income for the capitation rate year to demonstrate the capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs.	The inclusion of an expected pre-tax net income will allow CMS and MCOs to review this assumption, in conjunction with other assumptions, to determine if capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs.
Section 1.A. xiii.	Add (g) to the list: (g) 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 of information states and their actuaries provide 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 of actuarial soundness concerns.

1-B. General Information – Appropriate Documentation		
Guide Section	**Suggested Revision/Addition**	**Rationale**
Section 1.B.ii.	Add (d) to the list: (d) A summary of information provided to MCOs and indicating if it is the same information sent to 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.	This will allow CMS to see what information is provided to MCOs (if different than what CMS receives).
Section 1.B.xi (new)	xi. Within 14 federal business days following receipt by MCOs, PIHPs or PAHPs of the rate certification and documentation of the capitation rate development, MCOs, PIHPs, or PAHPs may submit page limited feedback regarding top actuarial soundness concerns of the capitation rates via email to CMS and the state. Feedback should include contact information for the MCO, PIHP, or PAHP for follow-up questions as needed.	Provides MCOs an opportunity to present their top actuarial soundness concerns to CMS. This is an important communication avenue given that certain actuarial soundness concerns may come to light once final capitation rates are received by the MCOs and can help CMS identify areas of interest that may require additional review.
2. Data		
Guide Section	**Suggested Revision/Addition**	**Rationale**
Section 2.A.i.(b)	Add to (b) the text in italics: (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 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.*	Given the disruption to the health care system caused by the COVID-19 PHE, there will need to be some flexibility in selecting appropriate base period data. If the most appropriate base data is from a pre-PHE time period that predates the rating period by more than three years, states should be permitted to propose use of that base data in rate setting. In such cases, state actuaries should provide a rationale for selecting that time period and the methodology/ assumptions used to adjust the data, given that COVID-19 PHE impacts may not be fully known.
5. Projected Non-Benefit Costs – Appropriate Documentation		
Guide Section	**Suggested Revision/Addition**	**Rationale**
Section 5.B.i	Add (d) to the list: (d) A description of the statistically based model and assumptions used to develop the	Medicaid managed care differs from other health programs in that the entity setting the capitation rates (price) is not usually the entity

	Underwriting Gain assumption; including the two major components of cost of capital and risk margin.	that must bear the risk of mispricing. CMS and Medicaid MCOs rely on state actuaries to develop capitation rates at levels that adequately fund the program, even in years of adverse deviation, so explicit inclusion of an adequate risk margin in the capitation rates is especially important.
Section 5.B. ii	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.*	Most state Medicaid program contracts now include limitations (e.g., risk sharing and withholds) that make underwriting gain a poor proxy for MCO percentage of net income. Therefore, a more precise analysis is required to determine an appropriate underwriting gain assumption.
Appendix A: CMS Medicaid Managed Care Rate Development Summary for Accelerated Rate Reviews		
Guide Section	**Suggested Revision/Addition**	**Rationale**
Introduction	Replace (2) with the following: (2) the full rate certification and related supporting documents, *including MCO actuarial soundness concerns*, and	Including actuarial soundness concerns raised by MCOs will increase transparency and provide CMS with another perspective on the appropriateness of an accelerated rate review.
#6	Replace 6 with the following: 6. No material issues have been identified (by any party, *including MCOs*) 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 there were material issues that were identified in rate setting during the prior rating period, and therefore states should give CMS *and MCOs* prior notice if their intention is to participate in the accelerated rate review.	Including MCOs in the definition of “any party” will clarify entities that can identify material issues and support CMS in identifying material issues in rate proposals.