

Response to Public Comments (GenIC #37): 2021-2022 Medicaid Managed Care Rate Development Guide

In the May 12, 2021 Federal Register (86 FR 26042), we published the Medicaid and Children's Health Insurance Program (CHIP) Generic Information Collection Activities: Proposed Collection; Comment Request for the 2021-2022 Medicaid Managed Care Rate Development Guide. States are required to submit rate certifications for all Medicaid managed care capitation rates per 42 CFR § 438.7. Our collection of information request specifies our requirements for the rate certification and details what types of documentation we expect to be included as well as our expectations for states when they submit rate certifications. We received 2 comment letters, which contained comments on multiple topics. Brief summaries of the public comments are included below with responses from CMS. Some comments were outside the scope of this collection of information request; they are not summarized nor responded to in this document. CMS is not proposing to make any changes to the 2021-2022 Medicaid Managed Care Rate Development Guide as a result of the comments and as explained in the responses included below.

Comment: Some commenters recommended 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. Commenters also recommended that CMS expand the Guide to provide a comprehensive reference for states, actuaries, Medicaid MCOs, and other stakeholders addressing all the relevant guidance and their impacts on rate setting standards.

Response: CMS does not believe that it should include additional guidance on the impacts of the public health emergency (PHE) in the 2021-2022 Medicaid Managed Care Rate Development Guide (Guide). CMS expects that the PHE impacts on Medicaid managed care capitation rates will vary across both states and programs and thus CMS would like to ensure that states retain the ability to evaluate and determine the approach that is most appropriate for their program(s). Additionally, the Guide provides references and links to the [CMCS Informational Bulletin published on May 14, 2020](#) and [COVID Frequently Asked Questions for State Medicaid and CHIP Agencies](#) for further information regarding rate development and risk mitigation considerations around the PHE. As the PHE is continuing and additional legislation may be forthcoming, it is not possible to provide comprehensive PHE information in this Guide. CMS is issuing guidance as it becomes available on individual statutory provisions and believe that is the most effective approach for such time-sensitive information.

Comment: Commenters recommended that CMS address requirements and conditions for including social determinants of health expenditures as quality improvement activities in capitation rates and minimum MLR remittance calculations.

Response: Activities that improve health care quality are clarified at 42 C.F.R. § 438.8(e)(3) and CMS has no regulatory requirements for including social determinants of health as activities that improve health care quality. Therefore, there is no need for additional information in the Guide.

Comment: Commenters recommended that the Guide should address the level of detail needed to establish that withholds or percentages thereof are reasonably achievable, 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.

Response: The Guide includes language that incorporates 42 C.F.R. § 438.6(b)(3) and indicates that rate certifications must include a description of how the total withhold arrangement, achievable or not, is

reasonable and takes into consideration the managed care plan's financial operating needs accounting for the size and characteristics of the populations covered under the contract, as well as the managed care plan's capital reserves as measured by the risk-based capital level, months of claims reserve, or other appropriate measure of reserves. Additionally, the Guide indicates that rate certifications must include an adequate description of the withhold arrangement including the purpose of the withhold arrangement (e.g., specified activities, targets, performance measures, or quality-based outcomes, etc.). The rate certification must also indicate that the capitation payment minus any portion of a withhold that is not reasonably achievable is determined as actuarially sound by an actuary. We decline to include additional documentation requirements about withholds and believe that requirements in Section I.4.B.ii of the Guide provide adequate information for CMS to conduct its review of Medicaid managed care capitation payments that include withhold arrangements.

Comment: Some commenters recommended that CMS state that rating periods other than 12 months would be allowed under certain circumstances.

Response: We decline to include additional statements indicating that CMS will allow rating periods other than 12 months under certain circumstances. 42 C.F.R. § 438.2 indicates a 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 submitted to CMS.

Comment: Some commenters recommended that rate certifications include additional statements regarding possible 1.5% changes to certified capitation rates.

Response: We decline to require additional statements about potential 1.5 percent changes to certified capitation rates. 42 C.F.R. § 438.7(c)(3) permits states to increase or decrease the capitation rate per rate cell up to 1.5 percent during the rating period without submitting a revised rate certification and requires that such changes of the capitation rate within the permissible 1.5 percent range must be consistent with a modification of the contract as required in 42 C.F.R. § 438.3(c). CMS, via 42 C.F.R. § 438.7(c)(3), deems any rate within 1.5% of the original certified rate to be considered actuarially sound, not the state's certifying actuary. We believe it would be inappropriate to require a certifying actuary to make this statement.

Comment: Commenters recommended that when states and their actuaries determine that a retroactive adjustment to capitation rates is needed that the certification demonstrate how the retroactive adjustment still maintains the projected (prospective) nature of capitation rate setting and allows MCOs to maintain efficiencies already achieved.

Response: We decline to require additional statements in the Guide regarding retroactive adjustments to capitation rates. 42 C.F.R. § 438.7(c)(2) indicates that if a state determines a retroactive adjustment to the capitation rate is necessary, the retroactive adjustment must be supported by a rationale for the adjustment and the data, and the assumptions and methodology must be adequately described to allow CMS or an actuary to determine the reasonableness of the adjustment. Additionally, the revised rates must be certified by an actuary as actuarially sound and submitted as a contract amendment to be approved by CMS. We believe unexpected events or programmatic changes can occur during a rating period that may necessitate a state to make a retroactive change or adjustment to the previously paid rates. We believe that Section I.1.A.iii.c.vi of the Guide already contains the documentation requirements needed in a rate certification to evaluate the reasonableness of a retroactive adjustment.

Comment: Commenters recommended that rate certifications include a projection of the estimated pre-tax net income for the capitation rate year.

Response: A projection of the estimated pre-tax net income is not required by regulation nor is it information that CMS needs to perform its rate review for actuarial soundness. We believe Section I.5.B of the Guide, which requires rate certifications to describe the development of the projected non-benefit costs included in the capitation rates, is appropriate and reflects our current regulatory requirements at 42 C.F.R. § 438.7(b)(3). As such, we decline to add this information to the Guide.

Comment: Some commenters recommended that 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 should be included in the rate certification. These commenters also recommended that the age or time periods of all the data used and a description of what the data was used for be included in rate certifications.

Response: 42 C.F.R. § 438.7(b) requires rate certifications to describe the base data used to develop the rates, how the actuary determined that the base data was appropriate to use for the rating period, as well as all trend factors, adjustments, risk adjustments, and any special contract provisions related to payment. Additionally, 42 C.F.R. § 438.5(c)(2) indicates states and their actuaries must use the most appropriate base data with the basis of the data being no older than the 3 most recent and complete years prior to the rating period for setting capitation rates. States that are unable to develop rates using data that is no older than from the 3 most recent and complete years prior to the rating period may request approval for an exception as per 42 C.F.R. § 438.5(c)(3). We believe these regulatory requirements encompass the additional information requested by commenters and are reflected in Section I.2 of the Guide. We believe the documentation requirements in the Guide provide CMS with sufficient information to evaluate actuarial soundness of the capitation payments.

Comment: Some commenters recommended that CMS require more detail on risk-sharing mechanisms, including development of the funding pool, rationale for the center point of the arrangement, width of risk-sharing bands, and methodology used to calculate the risk-sharing arrangement result, and the formula.

Response: We decline to adopt these recommendations as most of them are already sufficiently addressed by the documentation requirements in Section I.4.C.ii of the Guide. For example, the Guide requires rate certifications to include a description of any risk-sharing arrangements including a rationale, a detailed description of how it is implemented, a description of any effect it may have on the development of the capitation rates, and documentation demonstrating that it has been developed in accordance with generally accepted actuarial principles and practices. There are additional documentation requirements in the Guide for risk-sharing mechanisms with a remittance/payment requirement and reinsurance requirements. We believe the documentation requirements in the Guide appropriately incorporate 42 C.F.R. § 438.6(b)(1) and provide CMS with sufficient information to evaluate the actuarial soundness of the certified capitation rates. Additionally, the annual report due from states pursuant to 42 C.F.R. § 438.74 also provides detailed information regarding any remittances related to risk-sharing mechanisms and these requirements do not need to be duplicated in the Guide.

Comment: Commenters recommended that CMS require documentation for additional categories within the non-benefit component of capitation rates.

Response: Section I.5.B of the Guide requires rate certifications to describe the development of the projected non-benefit costs included in the capitation rates in enough detail so CMS or an actuary applying generally accepted actuarial principles and practices can identify each type of non-benefit expense that is included in the rate and evaluate the reasonableness of the cost assumptions underlying each expense in accordance with 42 C.F.R. § 438.7(b)(3). Additionally, 42 C.F.R. § 438.5(e) defines the

non-benefit component of the rate as including reasonable, appropriate, and attainable expenses related to health plan administration, taxes, licensing, and regulatory fees, contribution to reserves, risk margin, cost of capital, and other operational costs associated with the provision of services. We believe the Guide appropriately incorporates these regulatory requirements and CMS does not need the suggested information to complete its review for actuarial soundness; therefore, there is no need for it to be included in the Guide.

Comment: Commenters recommended that CMS require additional documentation on the development and achievability of other payment structures, incentives, or disincentives that states pay to managed care plans in managed long-term services and supports (MLTSS) programs.

Response: All Medicaid managed care rates are subject to the actuarial soundness requirements in 42 C.F.R. § 438.4 and this includes rates for long-term services and supports as defined at 42 C.F.R. § 438.2(a). Section II.1.C.i.c of the Guide requires the rate certification to provide documentation regarding any payment structures, incentives or disincentives states use to pay managed care plans in MLTSS programs. CMS believes that this requirement sufficiently addresses the regulatory requirements and additional information is not needed for CMS to complete its review for actuarial soundness. As such, there is no need for it to be included in the Guide.