

## **Response to Public Comments (GenIC #37): 2022-2023 Medicaid Managed Care Rate Development Guide**

In the February 8, 2022 Federal Register (87 FR 7177), we published the Medicaid and Children's Health Insurance Program (CHIP) Generic Information Collection Activities: Proposed Collection; Comment Request for the 2022-2023 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 2022-2023 Medicaid Managed Care Rate Development Guide as a result of the comments and as explained in the responses included below.

**Comment:** Some commenters expressed concern that the 2022-2023 Medicaid Managed Care Rate Development Guide (Guide) requires base period data to be within the most recent three-year period as the COVID-19 public health emergency (PHE) may have impacted the 2020 and 2021 experience and associated trends which may not be an appropriate data source for rate development in 2022 and 2023.

**Response:** Per 42 CFR § 438.7(b), states are required to ensure rate certifications describe the base data used to develop the rates, and 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 and non-benefit component of the rate. Additionally, 42 CFR § 438.5(c)(2) requires that states and their actuaries 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. This requirement allows states' actuaries to continue to use base data prior to the public health emergency. Additionally, states that are unable to develop rates using base 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 CFR § 438.5(c)(3). We believe these regulatory requirements address the concerns expressed by commenters and are reflected in Section I.2 of the Guide. Additionally, the documentation requirements described in the Guide provide CMS with sufficient information to evaluate actuarial soundness of the capitation payments and we decline to include any additional requirements in the Guide.

**Comment:** One commenter indicated CMS should be proactive in providing detailed, specific requirements and expectations as to how actuaries must account for COVID-19 impacts. Another commenter indicated that they appreciated that the Guide has a more robust set of expectations to document assumptions pertaining to the rate development impacted by the COVID-19 PHE and encouraged CMS to continue proactive engagement with states as they learn from the complexities of rate setting during this time.

**Response:** CMS does not believe that it should include additional guidance on the impacts of the PHE in the 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 and their actuaries 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. We believe the documentation requirements currently reflected in the Guide provide CMS with sufficient information to evaluate actuarial soundness of the capitation payments and decline to include any additional requirements.

Comment: One commenter indicated CMS should require actuaries to evaluate the impacts of COVID on any quality bonuses or withhold arrangements included in rate certifications.

Response: The Guide includes language that incorporates 42 CFR § 438.6(b)(2) and (3) and indicates that rate certifications must include a description of any incentive payments and/or withhold arrangements that state has with managed care plans. For incentive arrangements, the state may not provide for payment in excess of 105% of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement. Additionally, the certification must indicate the time period of the incentive arrangement, the enrollees, services and providers covered by the incentive arrangement and the purpose of the incentive arrangement (e.g., specified activities, targets, performance measures, or quality-based outcomes, etc.). For any withhold arrangement, the rate certification must describe 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 incentive payments and withhold arrangements and believe that requirements in Section I.4.A and B of the Guide provide adequate information for CMS to conduct its review of Medicaid managed care capitation payments that include incentive payments and/or withhold arrangements.

Comment: Some commenters recommended that CMS expand the guidance for risk mitigation strategies to include criteria or market conditions that states must consider when implementing risk sharing mechanisms.

Response: We decline to adopt this recommendation as we believe the documentation requirements in Section I.4.C.ii of the Guide appropriately incorporate 42 CFR § 438.6(b)(1) with regard to risk sharing mechanisms and provide CMS with sufficient information to evaluate the actuarial soundness of the certified capitation rates. CMS has no regulatory requirements for including the additional guidance recommended. Therefore, there is no need for additional information in the Guide.

Comment: Some commenters asked that CMS ensure a sufficient level of detail on the risk-sharing arrangement to ensure impact on rates and contracts can be fully understood by all partners.

Response: CMS believes this is 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 current documentation requirements in the Guide appropriately incorporate 42 CFR § 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 CFR § 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: Some commenters recommended that CMS address requirements and conditions for including social barriers 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 CFR § 438.8(e)(3) and CMS has no regulatory requirements for including social barriers of health as activities that improve health care quality. Therefore, there is no need for additional information in the Guide.

Comment: Some commenters recommended that the Guide clarify for states that actuarial soundness also applies to adequate coverage of non-benefit costs when developing capitation rates to achieve a minimum MLR.

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 CFR § 438.7(b)(3). Additionally, 42 CFR § 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: Some commenters recommended requiring a model-based approach to develop the underwriting gain and include additional requirements around the documentation provided in rate certifications regarding the development of the underwriting gain assumption.

Response: A model-based approach for the development of the underwriting gain assumption is not required by regulation nor is it required for CMS 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 CFR § 438.7(b)(3). As such, we decline to add this information to the Guide.