April 24, 2023

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Attention: CMS–10108
Mail Stop C4–26–05
Baltimore, MD 21244–1850

**Re: PRA Notice, Medicaid Managed Care and Supporting Regulations; File Code CMS–10398**

Dear Administrator Brooks-LaSure:

The Medicaid Health Plans of America (MHPA) is pleased to have this opportunity to respond to your request for comment on the Notice published in the Federal Register on April 10, 2023, related to the revision of the currently approved collection of information for the Medicaid Managed Care Rate Development Guide (the Guide). The Guide is an important resource for states, Medicaid health plans, and stakeholders, and we appreciate the opportunity to provide comments.

MHPA is the only national trade association with a sole focus on Medicaid, representing more than 130 MCOs serving more than 50 million Medicaid beneficiaries in 40 states, the District of Columbia and Puerto Rico. MHPA's members include both for-profit and non-profit, national, regional, as well as single-state health plans that compete in the Medicaid market. Nearly three-quarters of all Medicaid beneficiaries receive health care through MCOs, and the Association provides research and advocacy services that support policy solutions to enhance the delivery and coordination of comprehensive, cost-effective, and quality health care for Medicaid beneficiaries.

While we continue to appreciate the opportunity to provide comments in response to the official release of the Guide, we strongly encourage the Centers for Medicare & Medicaid Services (CMS) to provide additional opportunities for feedback on Medicaid managed care rate setting throughout the year. As we shared in our comments last year, we believe 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. 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.

Key areas of focus for MHPA include the establishment of clear risk-sharing arrangements prior to the rate period, clarity on the treatment of COVID-19 impacted data, and transparency in rate range development and underwriting gain assumptions.

*Risk-Sharing Arrangements*

*COVID-19 Risk Corridors*

The COVID-19 pandemic underscored the Medicaid program's role as a critical lifeline for our nation's most vulnerable populations. Given the unprecedented nature of the COVID-19 pandemic, we appreciate efforts by the CMS to better understand how risk corridors were leveraged by states to reduce uncertainty surrounding utilization and health outcomes for individuals enrolled in Medicaid, especially considering the speed at which these provisions were put into place. Ensuring that data collection tools are standardized across states will facilitate a better understanding of how state approaches to risk mitigation during the COVID-19 pandemic differed, as well as how Medicaid managed care organizations (MCOs) performed during the public health emergency (PHE).

As indicated in our March 2023 letter to CMS on risk mitigation,[1] we encourage CMS to consider rate setting and existing risk mitigation arrangements in the context of the full actuarial environment for Medicaid managed care.

Risk corridors operate in a complex actuarial environment and should be viewed in the context of other mechanisms and the full scope of rate setting arrangements unique to each state. The 2016 Medicaid Managed Care Rule requires that capitation rates for MCOs be set such that the MCO would achieve a Medical Loss Ratio (MLR) of at least 85%, ensuring that Medicaid funding is spent appropriately. In addition, certain states require profit caps for Medicaid MCOs as well as requirements to reinvest revenue into infrastructure to promote access to care. Medicaid MCOs also make significant investments in addressing social determinants of health (SDOH) via value-added benefits and in lieu of services. These investments aid states in building provider capacity and help beneficiaries to stay healthier but are often administrative costs for health plans. Further, while we appreciate and applaud CMS for taking proactive steps to ensure that states and health plans were well positioned to meet the evolving needs of beneficiaries during the COVID-19 pandemic, the shifting regulatory environment resulted in an administrative burden for states and health plans as they sought to maintain compliance with new flexibilities and requirements. To the extent that CMS seeks to evaluate the performance of MCOs during the COVID-19 pandemic, we encourage analysis to capture the full actuarial landscape described above.

We encourage CMS to limit COVID-19 risk corridors to the 2024 rating period at the latest. CMS states in the Guide that corridors can apply until enrollment is expected to stabilize; we are concerned that the phrasing lacks specificity and that states could interpret this to include CY 2025 and CY 2026 rating periods, when enrollment should be stabilized. We ask that CMS provide clarity on this issue to reduce uncertainty for managed care organizations and to promote investment in managed care.

We also recommend CMS limit the scope of COVID-19 risk corridors to not include the LTSS population, who are less likely to be disenrolled during the unwinding period and should therefore not be materially affected in pricing and risk mitigation basis.

[1] https://medicaidplans.org/wp-content/uploads/2023/03/MHPA-Comments-CMS-Risk-Mitigation-03202023.pdf

*Prospective Risk-Sharing Arrangements*
We appreciate CMS's efforts to ensure states detail any risk sharing arrangements prior to the start of the rating period. The complexities of rate setting and the nuances of risk-sharing arrangements matter when determining the appropriateness of rates for a specific contract and rating period. As CMS accepts states' submissions of draft managed care contract actions that are not officially executed and documentation from a state's actuary that may not reflect final full rate development or is limited to a description of the risk sharing arrangement(s), we ask 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. We appreciate that CMS notes the requirement that final, executed contract and rate certification documents must be unchanged from the prior submission to CMS for the risk mitigation arrangement(s) to be approvable under 42 C.F.R. 438.6(b)(1). We ask that timeliness of these decisions as well as inclusion of impacted MCOs in communication regarding approvals is accounted for in this process.

Further, we ask for clarification on whether CMS is accepting new 1115 risk mitigation waivers, which waive the requirement that risk mitigation strategies be prospectively captured in contract and rate certification documents.

*Special Contract Provisions Related to Payment*
In conformity with regulations at 42 CFR 438.6, we recommend CMS clarify that quality programs increasing or decreasing an MCO's capitation rate based on performance align their measurement periods with the applicable rating period. This clarification will provide transparency to MCOs and ensure that they are able to operationalize improvements to meet the quality objectives for that rating period prospectively.

*Rate Range Certifications*

In the context of the wind-down of continuous coverage requirements, member acuity can shift during a rating period. We seek clarity on the impact to rate ranges when the actuary who initially certified a rate range identifies an increase in population acuity exceeding 1%. Is the certifying actuary authorized to certify a new rate range during the rate year that reflects this change in population acuity, assuming it was unknown or incorrectly reflected in initial rates? In this instance, would the entire rate range move up or down to reflect the corrected acuity assumption and/or methodology?

We applaud CMS for requiring that any eligibility or enrollment criteria that could have significant influence on specific population to be covered within the managed care program to be included in acceptable rate certification submissions. This transparency will improve the ability of states and plans to plan around the unwinding period. We appreciate CMS reiterating in this year's Guide that states must develop and certify a range of capitation rates per rate cell as actuarially sound. This level of granularity is critical when measuring the acuity of subpopulations within Medicaid.

*Leveraging Pre-Pandemic Base and Trend Data*

As levels of member utilization and acuity revert to pre-pandemic levels, we commend CMS for laying out a streamlined pathway for states to leverage base data in their rate assumptions from

before the COVID-19 pandemic. Given the unprecedented nature of COVID-19, there may be situations where pre-COVID base data is a more reliable starting point than more recent data affected by the pandemic.

We raise concerns with CMS not providing guidance allowing states to rely on data from pre-pandemic periods to project benefit cost trends in the context of rate certifications. As discussed above, leveraging pre-pandemic data will result in more accurate rate certifications.

*Transparent and Quantitative Approach to Underwriting Gain Assumption Development*

We encourage CMS to require additional transparency and a model-based approach for the development of the underwriting gain assumption in capitation rate development which will support the financial stability of managed Medicaid programs. We appreciate 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. As we have shared previously with the agency, MHPA believes that state adherence to two essential programmatic principles and safeguards, actuarial soundness and transparency protections, will support the Medicaid program's stability and sustainability by allowing for continued financial viability of state partner Medicaid MCOs.

Thank you for the opportunity to provide feedback on the Guide. We believe the comment opportunity demonstrates your commitment to 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,

/s/

Shannon Attanasio
Vice President, Government Relations and Advocacy