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Ms. Rebecca Burch-Mack
Mr. William N. Parham, III
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Centers for Medicare and Medicaid Services
7500 Security Boulevard, Room C4-26-05
Baltimore, MD 21244-1850

Via electronic submission to www.regulations.gov

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

Dear Ms. Burch-Mack and Mr. Parham:

Medicaid is an essential program in the landscape of American health care, and Medicaid managed care organizations (MCOs) are committed to ensuring Medicaid is effective, affordable, and accountable. With that commitment in mind, AHIP[1] and its member Medicaid health plans appreciate the opportunity to provide comments on the draft *2022-23 Medicaid Managed Care Rate Development Guide* (the "Rate Guide").

In 40 states, Washington DC, and Puerto Rico, Medicaid programs contract with Medicaid MCOs to serve their enrollees. Nationwide, Medicaid MCOs enroll and serve more than 60 million people, nearly three-quarters of all Medicaid enrollees. Although states administer Medicaid eligibility and enrollment processes, 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.[2]

[1] AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together we are *Guiding Greater Health.*

[2] "The Value of Medicaid: Providing Access to Care and Preventive Health Services"; AHIP, 2018; accessed at https://www.ahip.org/documents/ValueMedicaid_Report_4.4.18.pdf

Federal law and regulations require states contracting with MCOs to set actuarially sound rates, and CMS has responsibility for reviewing and approving those rates. This process is critically important: it ensures that federal funds are used effectively and efficiently, and that Medicaid MCOs have adequate resources to ensure their contracted provider networks are accessible and deliver all contracted services to the low income and vulnerable populations they serve.

CMS updates the Rate Guide each year as a key resource for state Medicaid programs to ensure the actuarial soundness of rates. As with last year's Rate Guide, the 2022-23 version includes guidance regarding rate-setting flexibilities provided to states in response to the COVID-19 public health emergency (PHE).

We believe the 2022-23 Rate Guide would benefit from further revisions to incorporate the requirements described in the various guidance documents promulgated over the past year in order to provide states and stakeholders with a coordinated package that provides necessary clarity on federal standards for Medicaid rate setting. We also urge CMS to ensure the Rate Guide reflects any additional changes in its rate review process adopted in light of the ongoing actuarial uncertainties caused by the COVID pandemic and to improve the overall process of developing rates. The remainder of this letter presents our comments and recommendations on these key issues.

1. **Accounting for Effects of COVID-19 on Base Period Data.** We are pleased to see that, in the draft Rate Guide sections on Rate Development Standards and Documentation, CMS is requiring detailed information as to how states are accounting for impacts of COVID-19 on costs and utilization, such as testing, treatment and vaccines covered on a non-risk basis outside of capitation rates. However, we note that the draft Rate Guide still requires base period data to be within the most recent three-year period. We are concerned that using 2020 and 2021 experience and associated trends as base periods without additional analysis or specific guidelines may significantly compromise the integrity of utilization and cost projections and the actuarial soundness of proposed rates for 2022 and 2023.

   As we noted in our comments last year, the COVID-19 PHE is a sustained event that is unprecedented in the history of the Medicaid program and has resulted in significant anomalies in cost and utilization data for 2020 and 2021. While the Rate Guide requires actuaries to describe the evaluation conducted and the rationale for COVID-related assumptions included in rate development, this approach places state actuaries in the position of making their own judgments regarding the relevance or irrelevance of various factors. We believe that CMS should be more proactive in providing detailed, specific requirements and expectations as to how actuaries must account for COVID-19 impacts so as to avoid those actuaries reaching different conclusions based on their own judgments and interpretations.

   Another aspect of rate setting likely to be affected by COVID-related utilization changes is that of quality measures and related financial impacts. MCOs may be hampered in their ability to meet historical thresholds for quality standards during quality measurement periods that

have overlapped with the pandemic due to pandemic-related reduced utilization. We urge CMS to consider requiring that certifications for rate proposals that include quality bonuses or withholds evaluate the impacts of COVID on the quality measures and the measurement period, and certify that such quality measures are reasonable and attainable. We also urge CMS to require that these analyses are disclosed to MCOs prior to the rating period.

2. **Clarifying Standards for Risk Mitigation Mechanisms.** Medicaid MCO regulations at 42 CFR 438.6 (b)(1) provide that "…all applicable risk-sharing mechanisms, such as reinsurance, risk corridors, or stop-loss limits, must be documented in the contract and rate certification documents for the rating period prior to the start of the rating period, and must be developed in accordance with § 438.4, the rate development standards in § 438.5, and generally accepted actuarial principles and practices. Risk-sharing mechanisms may not be added or modified after the start of the rating period." Over the course of the COVID-19 PHE, states took various approaches to introducing or modifying risk sharing mechanisms. We are pleased to note that CMS includes additional guidance on this topic in the draft 2022-23 Rate Guide, emphasizing the regulatory requirement that risk mitigation strategies be prospective and included in contracts and rate certifications prior to the start of a rate period, and specifying required documentation and issues to be addressed in rate filings. We ask CMS to consider expanding the guidance to include criteria or market conditions that states must consider when implementing risk sharing mechanisms.

   We note that CMS has taken actions to waive this regulatory requirement and approve retroactive state risk mitigation proposals under Section 1115 demonstration authority for rating periods that overlap with the COVID PHE. The CMS approvals reference various state proposals for retroactive rate and risk mitigation changes, but neither the CMS approvals nor the proposals themselves include details on the specific changes. We have previously shared with CMS our serious concerns about flexibilities CMS granted states relating to retroactive rate and risk mitigation provisions in response to the PHE. We continue to believe a number of these proposals are inconsistent with actuarial soundness, such as asymmetric risk corridors, and retroactive changes extending to periods prior to the beginning of the COVID-19 PHE. The lack of easily accessible information about the proposed changes makes it even more difficult to assess the implications of these waivers. And as the PHE continues, we are concerned that ongoing approvals of rates and risk mitigation techniques proposed earlier in the pandemic may result in additional requests for retroactive rate and risk mitigation provisions and cause confusion and an expectation in some states that CMS has effectively rescinded the regulatory requirements entirely. Therefore, we ask that CMS include in the final 2022-23 Rate Guide a detailed discussion of the risk mitigation strategies approved in these waivers, the context of the approvals within the PHE, and the limits of these waivers in the context of the PHE.

   In its approval letters, CMS notes that it approved these risk mitigation proposals "to test whether, in the context of the current COVID-19 PHE, an exemption from the regulatory prohibition in 42 CFR § 438.6(b)(1) promotes the objectives of Medicaid." CMS states it

"will investigate how providing this authority results in either increased or decreased payments to plans, given the significant fluctuations in utilization that may occur during a pandemic. In addition, CMS's managed care oversight efforts will include an assessment of whether and how payments under the retroactive risk mitigation arrangements, which must be developed in accordance with all other applicable requirements in 42 CFR § 438, including §§ 438.4 and 438.5, and generally accepted actuarial principles and practices, are sufficient to cover costs under the managed care contract." The implications of these waiver are significant, so we encourage CMS to examine and publicize its assessments of these waivers and incorporate those findings as requirements and restrictions in future editions of the Rate Guide.

Also, we again recommend that CMS convene a technical expert panel (TEP) to develop consensus standards for key elements of risk sharing mechanisms, such as: calculating uncertainty in prospective rate setting, width and symmetry of risk corridor bands, calculating MCO obligations, and use of federal MLR definitions in risk corridors. Such a TEP ideally would include representatives from CMS, state Medicaid agencies, consulting and MCO actuaries, and the American Academy of Actuaries and Society of Actuaries.

3. **Encouraging Best Practices that Include MCOs in the Rate Development Process.** As noted, Medicaid MCOs now serve nearly three quarters of Medicaid enrollees in 42 Medicaid programs, providing operational capacity and expertise that connects members with care, coordinates care among providers, administers payments to providers, and reports on the results of operations to states. Despite the prominent role that MCOs play in working on behalf of states to deliver Medicaid coverage to the people who rely on it, states vary considerably in their levels of engagement and consultation with MCOs, including rate setting. While some states are very transparent in their communications with MCOs on details of rate proposals, such as base data, assumptions, and calculations, and solicit MCO input so that resulting proposed rates have been generally vetted prior to submission to CMS, others offer much less transparency and communication.

   We believe that Medicaid programs and their stakeholders – enrollees, providers, states, CMS and Medicaid MCOs – are best served when states and MCOs engage and consult openly on rate issues. In finalizing the draft Rate Guide, at a minimum, we ask CMS to expand the requirement on page 12 – "to provide adequate detail such that CMS is able to determine whether or not regulatory standards are met" – to include disclosure of the same materials and level of detail to the state's contracted MCOs. We again urge CMS to expand the Rate Guide to highlight best practices in collaboratiion on rate setting and convey its expectation to states that they engage and consult more directly with MCOs in developing rates.

   In addition, we request again that CMS publish the draft Rate Guide each year with a 30-day comment period, given the significance of Medicaid rate setting. We very much appreciate the opportunity for comment, but additional time to review the draft Rate Guide and develop

comments would be helpful in identifying additional areas for clarification and highlighting guidance applicable to emerging trends or issues in specific states.

4. **Clarifying the Use of Minimum Medical Loss Ratio (MLR) Requirements in Rate Setting.** While the draft Rate Guide makes a number of important references to MLR requirements, it would benefit from clarifications on two important rate setting implications.

    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 draft Rate Guide mentions these regulatory requirements, but we believe it needs to further emphasize and clarify for states that actuarial soundness also applies to adequate coverage of non-benefit costs (e.g., administrative costs, quality improvement activities, and underwriting gain).

    b. Social Barriers to Health. CMS, states, and Medicaid MCOs have increasingly taken steps to address impacts of social barriers to health on the health status and outcomes of Medicaid enrollees. These efforts include contracting with Medicaid MCOs to conduct social barriers identification and mitigation. 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 recommend that the Rate Guide clarify requirements and conditions under which these expenditures qualify as quality improvement activities in capitation rates and minimum MLR remittance calculations. In turn, this will encourage greater investments in services that reduce health disparities and promote health equity and reduce long-term Medicaid program costs.

5. **Withdraw or Delay Accelerated Rate Review.** AHIP continues to have concerns with the Accelerated Rate Review process first introduced in 2020 and continued in the draft 2022-23 Rate Guide. The Accelerated Rate Review process may compromise CMS' statutory obligation to oversee and ensure state payment rates are actuarially sound, and that potential continues to be compounded by the significant impacts of the ongoing COVID-19 PHE on patterns of care and costs. As long as COVID impacts on cost and utilization remain a factor in base period data and projections to future years, comprehensive reviews of full rate certifications and documentation remain necessary. We urge CMS to reconsider the accelerated review process. At a minimum, we strongly recommend that a moratorium be imposed on accelerated reviews until COVID-related impacts are no longer significant factors in base period costs and utilization.

6. **CMS Oversight of Federal Investments in Medicaid.** In our comments on last year's Rate Guide, we noted that on average, the federal government pays over two-thirds of the cost of

Medicaid and that CMS has a compelling interest in overseeing and ensuring the effectiveness, sustainability, and integrity of federal investments in the Medicaid program. However, the guidance in the draft Rate Guide appears to continue to reflect a perspective that Medicaid capitation rates are primarily a contractual matter between states and Medicaid MCOs, without a significant federal government interest. We continue to believe this perspective is inconsistent with federal financial investments in Medicaid and 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. Therefore, we again urge CMS to ensure that the Rate Guide, other CMS guidance, and the agency's internal processes all clearly support CMS' active role in assessing the data, assumptions, calculations, and projections included in state rate proposals.

We want to thank you again for the opportunity to comment on the 2022-23 Rate Guide and for considering our comments and recommendations. AHIP is committed to maintaining 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 taxpayers who support 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