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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: Managed Care Rate Setting Guidance (CMS-10398 #37)

Dear Ms. Burch-Mack and Mr. Parham:

Medicaid is an essential program in the landscape of American health care. Medicaid managed care organizations (MCOs) are a key part of this system. Medicaid MCOs contract with Medicaid programs in 40 states, Washington DC, and Puerto Rico to serve about three-quarters of all Medicaid enrollees nationwide. To ensure that federal funds paid to Medicaid MCOs are used effectively and efficiently and MCOs have adequate resources to make all contracted services available and accessible to people with Medicaid, federal law requires that states contracting with MCOs set actuarially sound rates. Given its importance in ensuring actuarial soundness, AHIP[1] and its member Medicaid health plans appreciate the opportunity to provide comments on the draft *2023-24 Medicaid Managed Care Rate Development Guide* (the "Rate Guide").

Revisions to this year's draft Rate Guide reflect CMS' continued efforts to integrate recent regulatory changes into the guide and address rate-setting issues related to the COVID-19 public health emergency (PHE). As discussed in more detail below, we appreciate and support several changes to the draft Rate Guide, including provisions that would increase state transparency relating to rate setting and address concerns that may arise if rates are based on data from years affected by the PHE. We also highlight requirements that we believe would benefit from additional clarifications and more detailed guidance. In addition, we address several issues and concerns relating to rate setting as Medicaid eligibility redeterminations re-start following the expiration of the Medicaid continuous enrollment period.

[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.*

The Value of Medicaid Managed Care

Medicaid MCOs are committed to ensuring Medicaid is effective, affordable, and accountable. Except for eligibility processes, Medicaid MCOs can manage a full range of functions for states and provide a variety of services to meet the unique needs of Medicaid enrollees. States choose which programs, populations, and services are covered by their Managed Care contracts. States can contract with Medicaid MCOs to coordinate and improve care and health outcomes; provide services that promote prevention and healthy living; connect enrollees with non-medical supports, such as social services or transportation; and perform functions such as customer service, provider network credentialing and quality, claims processing, reporting, and program integrity.

Medicaid MCOs improve quality for enrollees and achieve cost savings for states and the federal government. For example:

- Medicaid MCO enrollees are more likely to receive preventive services, have fewer hospital admissions, and have better access to primary care than enrollees in fee-for-service programs.[2]
- They save billions of dollars for the Medicaid program on prescription drug costs.[3]
- Medicaid MCOs also play a key role in reducing health disparities and advancing health equity in the places where Medicaid enrollees live and work.[4]

Detailed Comments on Draft Rate Guide

The following are our comments and recommendations on the draft Rate Guide:

1. **Applicability of actuarial soundness standards to Dual Eligible Special Needs Plans.** On page 4, "Section 1. General Information – Rate Development Standards", **we support CMS' addition of "dual eligible special needs plans (D-SNPs) under contract with a State Medicaid agency" to the types of managed care plans subject to the provisions of the Rate Guide**. This addition ensures that the Rate Guide aligns with CMS' prior guidance that capitation rates developed for Medicaid managed care contracts between a state and D-SNP must meet Medicaid managed care actuarial soundness requirements.

2. **Permissible circumstances for retroactive rate adjustments.** On page 6, Subsection iii-(c)-vi of "Section 1. General Information – Rate Development Standards," the Rate Guide would continue to permit retroactive rate adjustments with a new rate certification or rate amendment. **We urge CMS to clarify that such retroactive adjustments are permitted**

[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

[3] "Integrating Medicaid Prescription Drug Coverage: Better Health Outcomes and Budget Savings"; AHIP, 2023; accessed at: https://www.ahip.org/documents/202304-AHIP_MedicaidRxCvg.pdf

[4] "Care that Is Fair and Just: Improving Health Equity Through Medicaid Managed Care"; AHIP, 2021; accessed at: https://www.ahip.org/documents/202111-AHIP_IB-HealthEquity-MMC_v03.pdf

only in the case of significant data errors or other omissions related to program changes.

3. **Rate ranges.**

    a. On page 8, "Section 1. General Information – Rate Development Standards" subsection A-viii-d, **we appreciate and support the language in the draft Rate Guide that specifies a rate certification relating to a range of capitation rates per rate cell must document the criteria for paying MCOs at different points within the range**. While we have expressed serious concerns in the past with the use of rate ranges, as long as they are permissible, this change would be an important step to enhance the transparency and integrity of the rate setting process.

    b. On page 9, subsection A-ix-d, **we also support the requirement to publish the upper and lower bounds of each rate cell on the state's website**.

4. **Risk mitigation strategies.**

    a. On page 9, "Section 1. General Information – Rate Development Standards" subsection A-xii, **we appreciate that CMS will require state actuaries to describe their evaluations and rationale for assumptions relating to the resumption of Medicaid eligibility determinations.** However, **we recommend that CMS provide more detailed guidance on its specific expectations for such descriptions**, given the unprecedented effort to redetermine Medicaid eligibility that will be unfolding over the coming year, including potential impacts on Medicaid risk pools.

    b. In that same section, on page 10, CMS recommends that states implement or continue two-sided risk mitigation strategies for the period of time following the end of the PHE until enrollment is expected to stabilize. **We reiterate prior recommendations that CMS instead advise states to make prospective rate adjustments to capture the estimated impact of Medicaid redeterminations over the coming year.** Our recommendations focus on the transparency of assumptions and projections on disenrollments over time; the monitoring of actual results compared to states' month-to-month projections and assumptions regarding acuity and utilization; and prospective rate adjustment to account for significant variances in enrollment, acuity, and utilization.

    However, for states that decide to implement risk corridors, **we recommend that the rate setting process in the Guide ensure that such corridors are developed and applied symmetrically, prospectively, and with bands wide enough (at least plus or minus 3% around the risk corridor midpoint) to encourage MCO efficiency. In addition, such corridors should use metrics that mirror the state's existing minimum medical loss ratio (MLR) requirements so as to simplify reporting and preserve the equitability of the risk sharing arrangement.**

c. On page 28, subsection (i)(a) of "Section 4. Special Contract Provisions Related to Payment, C. Risk Sharing Mechanisms," the draft Rate Guide provides that "arrangements must be documented in the contract(s) and rate certification documents for the rating period prior to the start of the rating period…" and "…may not be added or modified after the start of the rating period." **We request that CMS specify that it will not permit exceptions to this requirement.**

5. **Exceptions for base data periods.** On page 17, "Section 2. Data – Rate Development Standards" subsection A-i-d-vi, the draft Rate Guide provides a streamlined exception process for states that are unable to use base data from the three most recent and complete years prior to the rating period. In discussing one part of that process related to the need for reasonable documentation explaining why an exception is necessary, CMS indicates that an example of acceptable documentation would be a state actuary's belief that older base data, with appropriate adjustments, is more appropriate given the impacts of the COVID-19 PHE on more recent base data. **We applaud CMS for making this very pragmatic exception process available for use by states and actuaries.** As we emerge from the COVID PHE, states and consulting actuaries are all facing different levels of uncertainty with respect to base year data in their respective states. Such Rate Guide flexibility appropriately recognizes these inherent challenges. In addition, **we recommend that CMS publish (or require states to publish) exception requests, documentation, and approvals.** This type of transparency will help states, actuaries, and other stakeholders to understand the kinds of base period data issues created by the COVID PHE.

6. **Impacts of COVID PHE on trend.** On page 19, "Section 3. Projected Benefit Costs and Trends," the Guide includes previous language requiring that Medicaid payment rates be based on historical trend. However, as indicated by the language on page 17 referenced above regarding the exceptions process, there is a risk that the COVID pandemic adversely impacted recent data, which can cause inappropriate negative trends. **We recommend that CMS expand this section with guidance on how states should account for anomalies in trends observed during the PHE and permit state actuaries a degree of latitude in accounting for the differences in projected vs. historically observed trends.**

7. **"In lieu of" services (ILOS).** On page 24, Subsection v. of "Section 3. Projected Benefit Costs and Trends, B. Appropriate Documentation," the Guide sets out the different documentation requirements for ILOS with material and non-material cost impacts on rates. Documentation requirements are discussed in more detail in "Appendix B. Documentation Expectations for the Actuarial Report Containing the Final ILOS Cost Percentage and Summary of Managed Care Plan Costs." Determining materiality of ILOS cost impacts is likely to be unfamiliar terrain for many states and actuaries. **We recommend that CMS consider providing general training for stakeholders and technical assistance to states and actuaries to promote a common understanding of these requirements.**

8. **Quality Incentive Programs.** On page 26, "4. Special Contract Provisions Related to Payment, A. Incentive Arrangements," the Guide describes rate development standards and documentation requirements for incentive arrangements. We are aware of at least one state that operates a quality incentive program that allows the state to establish new quality targets and apply those targets retroactively to adjust prospective capitation rates. This appears to be inconsistent with 42 CFR § 438.6. **We urge CMS to revise Section 4 to specify that all capitation rate adjustments linked to attaining quality metrics must be established and communicated prospectively, prior to the start of the rating period.**

9. **Acuity Adjustments.**

    a. On pages 46-47, subsection i-(b) of "Section 7. Acuity Adjustments, A. Development Standards," the Rate Guide gives examples of situations in which acuity adjustments should be considered. **We recommend adding another significant and current example: uncertainty regarding the acuity of the population due to the resumption of Medicaid eligibility redeterminations.** As noted above, we support processes designed to monitor and make prospective acuity adjustments as needed. However, in some cases retroactive acuity adjustments may be necessary to ensure capitation rates are appropriate. Accordingly, **we recommend explicitly listing redeterminations as an appropriate trigger for retroactive acuity adjustments.**

    b. Also in this section, on page 47, the draft Rate Guide addresses potential retrospective acuity adjustments when a state actuary is certifying rate ranges. The draft Rate Guide indicates that if a retrospective acuity adjustment results in revisions to the capitation rates, the state must utilize the *de minimis* flexibility in accordance with 42 CFR § 438.4(c)(2)(ii)-(iii) and the state does not have the option to utilize a rate amendment as it does not meet the criteria required in 42 CFR § 438.4(c)(2)(iii)(A)-(C). However, our understanding is that if experience indicates a rate change is required but results in an impact of greater than 1%, a state actuary could move the whole rate range if the actuary completes a new updated certification. **We request that CMS clarify whether rate change of greater than 1% would be permissible, provided that the actuary submitted a new certification.**

In closing, we thank you again for the opportunity to comment on the 2023-24 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