



January 14th, 2019

Administrator Seema Verma
The Centers for Medicare Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–2408-P, P.O. Box 8016 Baltimore, MD 21244–8013

Submitted electronically via email to <http://www.regulations.gov>

Re: Medicaid Program; Medicaid and Children’s Health Insurance Plan (CHIP) Managed Care

Dear Administrator Verma,

The Medicaid Health Plans of America (MHPA) appreciates the opportunity to comment on The Centers for Medicare & Medicaid’s (CMS) proposed rule for the Medicaid and Children’s Health Insurance Plan (CHIP) Managed Care program. MHPA is the national trade association representing 93 private-sector health plans that contract with State Medicaid agencies in 39 States plus DC to provide comprehensive, high-quality health care to more than 25 million Medicaid enrollees in a coordinated and cost-effective way.

According to recent figures, 300 Medicaid managed care organizations in 37 States and the District of Columbia cover more than 55 million Medicaid members. This number continues to rise annually as more States turn to the expertise of managed care plans to help coordinate health care for a growing number of Medicaid enrollees with diverse needs. As the program continues to absorb high acuity populations (i.e. MLTSS), and those remaining States contemplate expansion of their Medicaid programs, the regulations governing the use of managed care must continue to evolve to reflect new marketplace realities and experiences.

In 2015, CMS embarked on an overhaul of the regulations that had governed managed care delivery mechanisms since 2002. This overhaul included fundamental changes to payment mechanisms (e.g. establishment of a Federal minimum medical loss ratio (MLR) of 85 percent); changes to the rate setting process; phasing out of the use of pass through of supplemental payments from States; additional

guidance on provider network adequacy; direction on managed long-term care services and supports (MLTSS); and alteration of appeals and grievance processes and timelines.

Since the publication of the final Medicaid managed care regulations in 2016, MHPA has continued to be a consistent and measured voice in the call for a reflection of practical efficiencies in the managed care regulations especially as related to rate setting, actuarial soundness, and the minimum medical loss ratio (MLR). We look forward to a continued collaboration with CMS and offer our collective industry expertise and perspective to help inform the future development and implementation of Medicaid managed care regulations.

While recognizing that most of the proposed changes are policy and technical corrections to the 2016 final rule, MHPA would like to take this opportunity to provide comments on some of the seminal provisions of the new proposed rule. In addition, we would encourage CMS to create more formal stakeholder engagement to develop policy going forward.

Standard Contract Requirements (§438.3)

In response to feedback from a number of States, CMS proposes to remove the requirement that Medicaid managed care plans must enter into a Coordination of Benefits Agreement (COB) directly with Medicare and instead would require contracts with managed care plans to specify the methodology by which the State would ensure that the managed care plans receive all appropriate crossover claims for which they are responsible. MHPA recognizes the potential efficiencies inherent in the proposed changes but offers a note of caution relating to the potentially opening the door to sub-par manual processes that States might adopt that could incur additional costs and unnecessary complexity.

Actuarial Soundness Standards (§438.4)/Option to Develop and Certify a Rate Range (§438.4(c))

The 2016 final rule included many items impacting actuarial soundness and capitation rate certification. CMS devoted significant sections of the rule to the process for developing capitation rates as well as considerations for developing the individual components that comprise the capitation rate. Many of those new requirements were designed to hold the Medicaid rate certification process to a level of standards and detail that is similar to what is required in commercial rate filings and Medicare Advantage bids.

The new proposed rule makes significant changes by reintroducing the certification of rate ranges. Rate ranges must conform to a number of parameters including an upper bound rate range that does not exceed the lower bound by 5%.

MHPA suggests that this range should be narrower. A rate range width of 5% appears excessive given the range of risk margin of 0.5-2.5% (with an average of 1.5-1.8 % across States in 2015) for MCOs. Rather than set a broad rate range, we suggest that the rate range should be narrow and recommend limiting the width to lesser of 2% or 2 x underwriting gain. Any decision on rate range width should also consider any withhold provisions and the materiality of the withhold provision magnitude on the viability of the rates at the lower boundary.

Also, in justifying rate ranges, States should not simply justify each factor in isolation, but must justify the occurrence of all of the factors together to support the upper and lower bounds of the rate range

e.g., a State assuming the lowest possible administrative costs is unlikely to also have the lowest possible medical costs.

We are concerned that without further guardrails this proposal could lead to rate levels that are actuarially unsound when used in competitive bidding situations. This new section could allow the State actuaries to develop a range around the bids, instead of independently developing rates or ranges that are actuarially sound based on their determination.

The example embedded in the preamble illustrates this risk. The example shares a procurement situation for a State that historically bid the administrative component of the capitation rate, but could have “realize[d] a lower rate” under the “State’s previous procurement process” (i.e., when ranges were an option). This implies that the State actuary, who has more information about the program than any MCO actuary, did not feel comfortable certifying a rate that included an MCO’s low administrative bid. The example implies that providing a range option would allow a State actuary to certify a range of rates that includes this low bid. If the State actuary were comfortable including the bid rate (or rate component), he or she could have certified the specific rates (vs. ranges).

We strongly support the additional transparency CMS proposes. It is critical to a functioning Medicaid program that the differences in assumptions between the lower and upper bounds of rate ranges are fully justified and explained. States are then clear about the scope and commitment of their program and MCOs can enter into agreements with a full understanding of the State’s expectations on and risks shifted to the MCO. We also agree that both the upper and lower bounds must be certified as actuarially sound, and that the rate certification should document the State’s criteria for paying MCOs, PIHPs, and PAHPs at different points within the rate range.

Commensurate to the call for transparency, States should consistently provide plans with the underlying data and assumptions that gird their rate development, prior to rates being submitted to CMS. In addition, within the context of the notice-and-comment period (e.g. similar to that of a 1115 waiver), CMS should provide the MCOs an opportunity to submit comments regarding high priority areas of concern. We support a prospective review and approval of rates in advance of the payment year, however this should not shorten the time the MCOs get to review the draft rates before they are submitted to CMS. In addition, we would recommend that States provide the rate certification to plans in the spirit of transparency and collaboration.

As another resource to encourage the quality of State rate submissions, CMS might consider producing a best practice toolkit for States on rate development transparency. For example, the toolkit could highlight State practices that encourage the provision of historical costs, trends, and assumptions to Medicaid MCOs. The industry has thoughts on such a toolkit that we would be happy to discuss them in future conversations with the agency.

Lastly, we request that CMS clarify roles regarding determining whether or not rates are actuarially sound. In other words, is CMS’ role to approve rates by checking to make sure the rates comply with the items listed in §438.4(b)(1-9) or is to actually certify that rates are actuarially sound?

Capitation Rate Development Practices that Increase Federal Costs and Vary with the Rate of Federal Financial Participation (FFP) (§438.4(b)(10) and (d))

The 2016 final rule stressed that differences among capitation rates must be based on generally accepted actuarial principles and practices and should not vary simply based on the aspect that one rate

may be paid at a different FFP thereby shifting funding from the State to the Federal government. Although rates and covered services are allowed to differ by population and program, CMS implies in the new proposal that the goal of the 2016 final rule was that States would not be allowed to target higher capitation rates for populations associated with higher FFP percentages simply to reduce States spending and take advantage of Federal spending.

In the proposed rule, CMS adds additional clarity with regards to language supporting the use assumptions, methodologies, and factors utilized for development of rates at different FFP percentages and how to evaluate them. More specifically, a State's capitation rates would not be allowed to utilize a higher profit or risk margin, factor in additional cost associated with higher contractually required reimbursement, or use a lower MLR remittance threshold for populations with higher FFP levels than is utilized for populations with the lowest average FFP.

While we fully support CMS's requirement that capitated rates be justified, MHPA does not support a list of prohibited practices. Prohibitions unnecessarily limit the flexibility necessary in managed care rate setting, and direct prohibitions may conflict with State actuaries' ability to certify actuarially sound rates or hamper States' ability to develop viable programs and support managed care innovations.

Finally, with respect to innovation, some populations may be subject to value-based contracting requirements, or States may require MCOs to fill coverage gaps in ways that the standard FFP population does not need. For example, the working adults may need access to afterhours care at rates much higher than the typical FFP population and unsurprisingly, afterhours care is generally more expensive. Different providers may be necessary—the standard population may utilize primarily pediatric and maternity care providers, while an expansion population may have a greater need for infectious disease, adult dental or mental health providers.

Special Contract Provisions Related to Payment (§438.6)/Risk-Sharing Mechanism Basic Requirements (§438.6(b))

The proposed rule would require risk-sharing mechanisms (i.e. reinsurance, risk corridors, and stop-loss limits) be documented in the contract and rate certification documents prior to the start of the rating period and prohibit retroactive additions or modification after the start of the rating period. MHPA generally supports having risk-sharing mechanisms clearly documented before the start of the rating period, but we believe that complete prohibition of adding or retroactively changing them is unnecessary, potentially harmful, and costly.

We recommend that CMS clarify that retroactive adjustments are permissible for program changes that are the result of State program, legislative, or regulatory changes. MCOs should not be required to cover mandatory benefit enhancements, for example, without rating changes. Unexpected market changes (i.e. pharmaceutical breakthroughs, pandemics) might justify retroactive changes to risk-sharing agreements. Similarly, new populations with complex conditions may give rise to unanticipated costs that could not have been reasonably anticipated or addressed prior to the beginning of the rating period. Even unanticipated effects from flawed auto-assignment mechanism could prejudice plans and necessitate retro-active adjustments.

Finally, MCOs have noticed increased activity related to other retroactive revenue adjustments. In an effort to maintain payment integrity and actuarial soundness, while being sensitive to MCOs' financial

stability and accounting processes, we recommend that CMS create a workgroup to develop guidelines regarding the timing of when and how revenue can be retroactively adjusted.

Delivery System and Provider Payment Initiatives Under MCO, PIHP, or PAHP Contracts (§438.6(a) and (c))

As finalized in the 2016 final rule, CMS permits States to, under certain circumstances, direct managed care plans expenditures under their contracts. During the intervening period, a number of States required managed care plans to adopt minimum rates.

Under the proposed rule, CMS would authorize States to become far more engaged in directing contractors to test certain value-based provider payment reforms tied to the State's quality improvement strategy. MHPA notes that in some instances specialties provider contract rates maybe market competitive, but less than the State fee schedule. Subsequently, some providers are refusing to participate in value-based quality initiatives. Therefore, rather than consider multi-year payment arrangement criteria, CMS should allow for market-based negotiations.

Pass-through Payments Under MCO, PIHP, and PAHP Contracts (§438.6(d))

The current rule creates an unlevel playing field between fee-for-service and managed care. The proposed rule would expand pass-through authority in order to enable States to incentivize the transition to managed care of new populations and services currently paid directly by the State on a fee-for-service basis. The new policy would apply to newly-included services, the transition period would be capped at 3 years, and the rule would cap total pass-through payments at current aggregate levels under the State plan.

However, while the proposed rule does attempt to ameliorate some of the policy impediments more remains to be done. For example, care in rural areas costs more than urban areas. Pass-through payments to physicians are one tool that State can use to ensure that rural beneficiaries receive the same care as those that live in more urban areas. MHPA asks that CMS consider a more elongated phase out (e.g. 5 years to comport to the duration of State 1115 demonstration waivers) to permit States to fully leverage the use of Medicaid managed care. This would help to mitigate any potential provider disruption and provide an adequate timeline for plans to conduct a retrospective analysis of their contracting arrangements and adjust accordingly.

Rate certification submission– Annual Guidance (§ 438.7)

We appreciate the annual guidance that has been provided over the last several years by CMS, and the commitment to provide it at least annually as outlined in the proposed regulation. This additional detail on the rate development documentation requirements and processes is beneficial to all stakeholders. Providing the guidance publicly promotes transparency which leads to more financially stable programs. To the extent that CMS determines that the proposed rule cannot be modified to address the below recommendations, we have the following additional suggestions (separated into two sections) with regards to the annual guidance:

- a. Suggested additional requirements – To further promote transparency and financial stability, we are suggesting the following with regards to the annual guidance:

- Process to collect stakeholder feedback on Annual Guidance - we recommend that CMS collect feedback from the public prior to updating guidance annually. For example, 60 days prior to issuance of new guidance, CMS could issue a notice allowing stakeholders to submit suggestions for additions and changes which could be due two weeks after the notice. CMS could then review feedback and determine what to reflect in the updated guidance.
 - Process to ensure adequate review of rates - we also recommend the following enhancements to the existing rate review process:
 - As mentioned previously, CMS should require States to provide copies of the submitted certification package and any follow-up communications to the MCOs in order to ensure a transparent process (with confidential information redacted). In some States, very limited rate development data and explanation is provided to the MCOs. Enhanced transparency at no extra cost will help ensure actuarially sound rates.
 - CMS should require States provide 30 days for MCOs to perform an adequate review and discussion of the draft rates, prior to CMS submission. We believe this is a reasonable amount of time to review and discuss the rate development with the State and the State’s actuaries, and allow them to make rate adjustments. Today, MCOs do not get adequate time to review draft rates in all States. Additionally, the requirements proposed for States selecting the rate range option will make it even more difficult for MCOs to have appropriate review and discussion time, since the States will be even busier getting the rate certification package submitted to CMS prior to the rating period. Appropriate review time will help ensure actuarially sound rates and financial stability.
 - As mentioned previously, CMS should allow for a “comment period” during which MCOs could share high priority concerns and CMS could take them into account as part of their approval process. We view this as an opportunity for the MCOs to help CMS better understand the complexities of each State’s rate development process.
- b. Suggested rate development positions - Based on our experience, we believe the annual guidance should include CMS’s positions on specific rate development items. We would like to work with CMS on other potential elements of the annual guidance through the feedback process suggested above. Some examples of items that we believe should be clarified include the following:
- Calculation definitions – CMS should provide the details of the +/- 1.5% rate change calculations so they are consistent and transparent (e.g., treatment of pass-through payments).
 - Budget impacts – CMS needs to re-emphasize that rates cannot be directly reduced for budget reasons (e.g. budget factors, caps). Even though this is not allowed today, States do make such adjustments. States should not be permitted to make reductions to rates for these reasons without corresponding reductions to MCO expenses.
 - Alignment of revenue with risk – CMS should continue to support the development of rate payment structures that best align with the MCOs’ population risk. This includes being open to newer models that promote better alignment.
 - Withholds – CMS should require that the State actuary include all appropriate information on the reasonableness of any withholds, prior to the start of the rating period, even in situations when the State chooses to certify rates vs. ranges. This would allow MCOs to

effectively manage to the underlying metrics and methodology and help States and the federal government achieve these specific goals.

- Social Determinants of Health - Given the recent increase in activities designed to treat the whole member by covering social determinants of health, we should work together to determine how to account for expenses related to these benefits/services in the rate development. Penalties and Sanctions – CMS should require the State actuary to consider penalties and sanctions as part of the actuarial certification, in determining if the rates are actuarially sound. These items have increased in numbers and amounts in some State contracts and are sometimes developed with a high probability that MCOs will need to pay significant amounts to the State, which reduces a plan’s overall revenue. Therefore, they are an item that should be considered when determining whether rates cover all appropriate, reasonable, and attainable costs.

Lastly, MHPA recommends that CMS only allow rates to change (without a revised certification) by no more than the lesser of a) the risk margin or b) 1.5%. This proposal captures CMS’ intent outlined in the 2016 final rule to limit the magnitude of the change to be no more than the risk margin assumption built into the capitation rates.

Beneficiary Information Requirements (§438.10)/Provider Directories (§438.10(h))

The proposed rule has made significant favorable changes towards requirements relating to beneficiary information. First, the rule would lengthen the time period governing when a managed care plan must notify enrollees that their physician has left the network. The current standard is 15 calendar days following notice of provider termination. The proposal would now lengthen that period to within 30 days of actual termination. Second, in aligning with the 21st Century Cures Act, the agency proposes to eliminate from managed care provider directories whether providers have undergone cultural competence training. The proposed rule would only require that managed care directories indicate whether providers have cultural and linguistic capabilities. Third, the rule would relax the frequency with which paper provider directories must be updated if contractors offer mobile-enabled directories. Updating paper directories is time-consuming and challenging, since provider networks can change frequently.

MHPA appreciates flexibility that CMS has shown in this area. Given printing schedules, even the most up-to-date paper directory is approximately 30 days old. Electronic directories are more current and more easily searchable, and technology allows an individual to create personalized directories instantly.

While we believe that beneficiaries are better served with electronic directories and we believe that paper directories are not worth the resources, costs and waste, given how quickly they can become updated, if CMS continues to require paper directories, it should allow Medicaid MCOs to issue paper directories by zip code—like Medicare—rather than by service area and only upon request. In some States, the entire State is a service area and providers in another part of a large State may not be helpful to beneficiaries.

Further, CMS should limit the requirement to update paper directories to once a year. Finally, CMS should clarify that mobile-enabled, electronic directories do not have to be printable PDFs, but alternatively could be searchable directories.

Network Adequacy Standards (§438.68)

In the final rule, CMS required States to develop and enforce network adequacy standards, while refraining from prescribing specific travel time or distance requirements (e.g., 30 minutes or 30 miles). Under existing rules, States are required to develop time and distance standards for a range of providers including primary care (adult and pediatric), OB/GYN standards, specialist (adult and pediatric), hospital, pharmacy, and pediatric dental. Additional provider types may be designated by CMS and would also be subject to travel time and distance access standards.

Under the proposed rule, instead of requiring time and distance standards for provider types within a managed care network, States would be able to implement a combination of “quantitative minimum access standards” (e.g. minimum provider-to-enrollee ratios; maximum distance traveled; etc.)

MHPA believes that these changes are positive steps and appropriately reflect the flexibility States have sought. This flexibility must of course be tempered with a requirement that any State standards be reasonable and achievable given the limitations of the “medical infrastructure” available in various service areas. We look forward to working with CMS on developing alternative standards, particularly in areas with unique challenges such as MLTSS.

Medicaid Managed Care Quality Rating System (QRS) (§438.334)

The 2016 final rule required CMS to develop a Quality Rating System. States have the option to use the to-be-determined CMS-developed model or establish their own QRS that would be substantially comparable. At this junction, the QRS is still in its nascent stages and MHPA continues to provide a robust engagement with CMS. We believe that in order to achieve a meaningful quality system, it must accommodate existing metrics that are appropriately informative to the varied health needs and demographics of the Medicaid population.

Consequently, States must have the flexibility to measure and validate factors that matter to the beneficiaries, while discarding those metrics which are misaligned. As CMS moves forward with the publication of a notice of a proposed QRS framework, MHPA will continue to advocate for a unique perspective on the measurement of quality within the Medicaid managed care framework. We are especially interested in working on developing measures that serve all populations including those for which there are unique measure development challenges such as LTSS.

Grievance and Appeal System; General Requirements (§§438.402 and 438.406)

MHPA applauds the proposed changes CMS has made to the grievance and appeal system. The proposed rule amends timeline for enrollees to request a State fair hearing to be “no less than 90 calendar days and no greater than 120 calendar days from the date” of the managed care organization’s notice of resolution. We recommend that CMS further clarify this proposal and select one time period (as opposed to a range) as this change may be confusing to members and difficult for plans to implement.

Additionally, we support the elimination of the submission requirement of a signed written appeal once an oral appeal has been submitted, making it easier for members and plans. Finally, we also support CMS' proposal that if payment is denied for a service in whole or in part because the claim was not clean, that the denial would not be considered an adverse benefit determination.

Enrollee Encounter Data (§438.242(c))

The proposed rule adds the "allowed and paid amount" fields to the required encounter data elements that are to be shared with CMS. We support CMS' efforts to improve transparency and appreciate their commitment to safeguard data protected by federal law from inappropriate use and disclosure.

Given the variety of contracting and subcontracting arrangements, consultation should occur between Medicaid plans, States, CMS on how best to define and implement this provision to ensure that all appropriate costs are captured for rate development. There should also be sufficient time for implementation.

Thank you for the opportunity to provide input on revisions to the Medicaid managed care regulations included in this proposed rule. We look forward to working with you to help implement these changes and welcome the opportunity for additional dialogue and collaboration with the agency as our plans continue to provide care to millions of Americans. We look forward to being invited to participate in future workgroups and advisory bodies related to roll-out of these regulations.

Sincerely,

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