



July 9, 2020

Mr. Calder Lynch, MHSA
Deputy Administrator and Director, Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Safeguarding Medicaid Program Sustainability through State-Medicaid Managed Care Partnerships

Dear Director Lynch:

Founded in 1995, the Medicaid Health Plans of America (MHPA) works on behalf of over 100 member health plans, which serve approximately 25 million Medicaid enrollees in 38 states, or about one-third of all Medicaid beneficiaries in states with managed care delivery systems. MHPA's members include both for-profit and non-profit, national and regional, as well as single-state health plans that compete in the Medicaid market. On behalf of MHPA, I write to thank you for your strong leadership and collaboration with Medicaid managed care organizations (MCOs) as well as to request additional guidance from the Centers for Medicare and Medicaid Services (CMS) to help protect the long-term fiscal integrity of the Medicaid program.

We commend CMS and particularly the Center for Medicaid and CHIP Services (CMCS) for its swift and decisive action as well as the considerable flexibility extended to stakeholders across the Medicaid health care delivery eco-system from the earliest stages of the COVID-19 pandemic to ensure that the health care needs of Medicaid beneficiaries continue to be met in an appropriate and timely manner.

As you know, MCOs continue to play an essential role in supporting their state Medicaid program partners and Medicaid beneficiaries during the ongoing public health crisis. The COVID-19 pandemic is a public health emergency with broad economic consequences across the states, including significant state budget shortfalls for the foreseeable future. A recent Kaiser Family Foundation survey found that "17 of 19 states with a budget projection for 2021 said that they would almost certainly or likely have a deficit."¹ Increased Medicaid costs due to higher enrollment (driven by higher unemployment) and pent-up demand as well as exacerbated health conditions from deferred care are expected to drive up costs for the Medicaid program – notably impacting state budgets – and to persist long after the expiration of the declared public health emergency and the elimination of the temporary increase to the Federal Medical Assistance Percentage (FMAP).

¹ Kaiser Family Foundation, *Early Look at Medicaid Spending and Enrollment Trends Amid COVID-19*, May 15, 2020. <https://www.kff.org/coronavirus-covid-19/issue-brief/early-look-at-medicaid-spending-and-enrollment-trends-amid-covid-19/>.

With an increase in Medicaid applications and an urgent need for COVID-19 related care, our member plans are well-positioned to continue to help states through innovative solutions that provide budget predictability and manage health care costs and risk. Medicaid services delivered through the managed care model are reflective of a successful public-private partnership and provide the necessary infrastructure to swiftly address new and emerging needs in the states. As states consider their options to address their budgetary challenges, MHPA wishes to underscore the value of working with Medicaid MCOs to ensure continued access to quality care for Medicaid beneficiaries.

To support and build upon the success of state-managed care partnerships in the Medicaid program, MHPA respectfully requests that CMS issue guidance to help protect the continued viability of state-Medicaid managed care partnerships and the long-term sustainability of the Medicaid program.

Current State Activity

Capitation Rate Setting

The capitation rate setting process is critical for ensuring that Medicaid health plans have reasonable and appropriate payment for managing the delivery of holistic health care solutions that provide desired health care outcomes for vulnerable Americans. Capitation rates influence payment rates that directly impact a provider's willingness to participate in the Medicaid program, which also affects access and the quality of services provided to Medicaid beneficiaries.

States have considered MCO capitation rate adjustments, both prospectively and retrospectively, during this COVID-19 pandemic. MHPA's concern is that many of these adjustments have been made too quickly, incompletely, and in a non-transparent fashion. We are also worried that regulations and guidance is being misinterpreted. These adjustments create uncertainty while potentially placing managed care programs in jeopardy and at financial risk. Below are several examples of these adjustments and misinterpretations:

- Many states have announced capitation rate changes but are not providing health plans with the information or data supporting these changes.
- Several states have sought a rate adjustment within the 1.5 percent de minimis rate change amount, but have not provided health plans with the information or data tying these reductions to changes in their contracts as required under 42 CFR 438.7(c)(3).
- A state made a retroactive reduction to capitation rates that was less than 1.5 percent and submitted a revised actuarial certification to CMS. Subsequently, the state made an additional retroactive reduction of 1.5 percent to the new capitation rates without submitting a revised actuarial certification, citing the change is within the 1.5 percent de minimis amount, while failing to acknowledge the total adjustment to the original rates exceeds 1.5 percent.
- Several states are proposing reductions to prospective capitation rates that do not take into account the full information available and adjust for only downward cost impacts, without

considering potential upward impacts; this approach creates bias in the rates such that they may not be reasonable, appropriate, and attainable, and thus may not be actuarially sound.

- Multiple states are implementing directed payments structures, some of significant magnitude, without providing health plans the data supporting the payments to ensure they do not exceed assumptions included in the capitation rate certification. With limited data and without a reconciliation process, these payment may result in losses for health plans even with the implementation of a risk mitigation program.
- Many states are requiring health plans to provide responses to rate changes and risk mitigation programs, and even sign new contract amendments, within unreasonable time frames, sometimes as short as one business day.

Risk Corridors

Risk corridors are a type of risk mitigation mechanism intended to alleviate pricing risks due to some level of uncertainty. Risk corridors are an important tool that can offer both states and MCOs some protection for the assumptions included in the rate setting process. Due to uncertainty regarding whether and how COVID-19 will affect future claims, several states are considering risk corridors related to MCO rate setting. However, MHPA is concerned how some of these risk corridors are being structured. For example, some states are applying their risk corridors retroactively to a period in time predating the pandemic, which is concerning because MCOs reasonably expected to be made whole for the costs incurred during that period. Below are a few other examples:

- Some states are proposing risk corridors for a limited period of time when utilization decreased without providing adequate risk mitigation throughout the public health emergency that takes into account expected increases in utilization.
- Two states commented to their MCO partners that CMS would not allow a risk corridor to span over multiple rating periods, without reference to a specific policy.
- Many states are structuring their risk corridors as outlined in the CMS Informational Bulletin on May 14th, 2020. However, there often is not sufficient consideration for the state's specific capitation rate structure. CMS' examples only consider medical costs and in states where the non-benefit costs are not consistent among health plans or are underfunded, health plans may be in a position to experience guaranteed losses. This is especially true when the corridor includes narrow bands around the medical costs.
- One state believes that current guidance requires two-sided risk corridors which does not seem to be specifically referenced; additional clarity around retainer payments, directed payments, and their nexus to risk corridors would be beneficial.
- Several states are developing risk corridors that are not consistent with CMS' recommendation in the May 14th CMS Informational Bulletin that the target be consistent with initial rate development assumptions.

- Multiple states are implementing narrow bands around the target in the risk corridor, but this has the unintended effect of removing incentives to appropriately manage care and ultimately penalizes efficient plans while rewarding inefficient plans.

Viability & Sustainability Safeguards

MHPA believes that each state’s efforts to ensure the sustainability of its Medicaid program should also support the continued financial viability of its partner MCOs. Specifically, MHPA recommends that states seeking to reduce Medicaid spending through their partner MCOs must adhere to two essential programmatic principles and safeguards, actuarial soundness and transparency protections.

Actuarial Soundness

Actuarial soundness is a “north star” for the partnership between states and MCOs, as well as for the overall sustainability of the Medicaid program. Policies related to actuarial soundness are intended to ensure that adequate funding is provided to MCOs to manage risk for healthcare services and related administrative expenses while protecting Medicaid enrollees.

Under the statutory mandate included in §1903(m)(2)(A)(iii) of the Social Security Act, capitated payments to risk-based managed care plans must be made on an “actuarially sound basis.” Codified in regulations at 42 CFR § 438.4, actuarially sound Medicaid capitation rates must be rates that “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.” The regulations also require that state Medicaid managed care rates be developed in accordance with generally accepted actuarial principles and practices, appropriate for the population and services, and certified by qualified actuaries. The regulations also set forth a number of requirements tied to setting actuarially sound rates that must be met or an explanation provided why the particular requirements are not applicable. States must document compliance with the rate-setting requirements and their justifications are subject to CMS review.

In the 2016 Medicaid Managed Care final rule, CMS reaffirmed the importance of actuarial soundness in the capitation rate development process, stating that the final rule “strengthens actuarial soundness payment provisions to promote the accountability of Medicaid managed care program rates.”

We believe actuarial soundness is a critical safeguard that:

- Is required by federal law and reiterated in CMS regulations and guidance;
- Encourages the participation of MCOs in the Medicaid market;
- Promotes Medicaid program sustainability by ensuring adequate payments to safety net providers and beneficiary access to care;
- Enables managed care partners to work with states to manage the risk of unknown health care costs;
- Provides transparency to ensure that immediate and long-term impacts of revisions, changes, or adjustments are clear and understood across stakeholders; and
- Supports innovation to improve health outcomes for Medicaid beneficiaries.

This requirement would benefit from additional oversight and assurances to support the continued success of state-managed care partnerships in the Medicaid program.

Transparency Protections

Ensuring transparency in the rate-setting process promotes active stakeholder engagement that supports greater clarity, the identification of issues, and better feedback. For meaningful engagement, MHPA believe transparency is a critical safeguard in the rate-setting process through:

- *Adequate Notice*: MCOs are informed of details or changes and provided a reasonable time to allow for a response that could include questions, clarifications, or confirmations.
- *Data Documentation*: Data that a state has relied on for the purposes of rate setting or changes to rates should be documented and made available to MCOs with adequate notice.
- *Engagement Opportunities*: States should provide for multiple opportunities for MCO engagement with their state partners related to rate setting or changes. These opportunities for engagement would allow for feedback that could identify the need for changes or adjustments, as required.

MHPA respectfully requests additional CMS guidance that promotes actuarial soundness and transparency protections. For your consideration, our specific recommendations are included in two tables in the attachment. Please note that many of these requests and suggestions touch upon previously discussed concerns; however, we believe addressing these topics is increasingly urgent given the impact of the public health emergency and pandemic on states and their budgets, the Medicaid program, and, most notably, Medicaid enrollees.

Thank you for your attention to this important matter. We recognize the importance of working collaboratively to address the multitude of issues stemming from the pandemic and its impacts on our nation's most vulnerable communities. MHPA's member plans are well-positioned to help the Medicaid program remain a viable and sustainable approach to meeting public health needs. We would be happy to schedule a meeting to discuss our request at your earliest convenience. Please feel free to reach out to me directly at 202-857-5771 or ckennedy@mhpa.org with any questions or should you need any additional information.

Sincerely,



Craig A. Kennedy, MPH
President and CEO
Medicaid Health Plans of America

Table 1

Viability & Sustainability Safeguards: Actuarial Soundness	
State Activity	Recommendations
Rate adjustments	Data should be made available and documentation provided to health plans in order to determine whether rate adjustments (retroactive or prospective) meet actuarial soundness requirement. Reiterate that CMS will continue to request and review state actuary's description/updated certification of rate changes, regardless of the amount of the rate change.
Use of the +/-1.5 percent de minimis rate change as described in 42 CFR 438.7(c)(3)	Provide clarification that rates with changes within the +/-1.5 percent de minimis still need to be actuarially sound and require contract language to: <ul style="list-style-type: none">• Describe the reason and data & methodology for calculating the rate change; and• Be co-signed by the state actuary, indicating that rates are still actuarially sound after the rate change up to +/- 1.5 percent.
Selective rate reductions being made without consideration for all other related rate increases and decreases	Reiterate that selective adjustments (e.g., items that just reduce rates) are not appropriate. CMS to provide a list of COVID19 related items that must be considered as part of rate development when adjustments are made both prospectively and retrospectively.
Directed Payments	Require states perform a reconciliation between actual COVID-19 related directed payments and what was originally assumed in the capitation rates absent the public health emergency and make adjustments to rates as necessary. With the submission of the pre-print and the supporting documentation related to rate impacts, require inclusion of a statement from the state's actuaries that the rates are actuarially sound. Provide draft pre-print to health plans before providing to CMS for review and comment.
Retainer Payments	Require states perform a reconciliation between actual COVID-19 related retainer payments and what was originally assumed in the capitation rates absent the public health emergency and make adjustments to rates as necessary.
Risk Corridors	Provide additional examples of corridors that provide larger bands that appropriately incentivize managed care as well as examples that consider non-benefit costs. (Note: MHPA would be available to work with CMS to develop such examples). Provide guidance the risk corridors structure and the components of the calculation should align with the structure of the capitation rates.

	<p>Provide clarification that risk corridors can span multiple rating periods and that corridors spanning from only during the time periods of expected reduced utilization or that are applied retroactively to time periods well before the pandemic do not provide appropriate protection and risk mitigation.</p> <p>Request CMS continue to review and approve risk mitigation programs and request the state’s actuary provide estimates of the impacts by plan.</p>
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Table 2

Viability & Sustainability Safeguard: Transparency Protections	
State Activity	Recommendation
Rate adjustment	<p>Request that states share information and detail behind assumptions and data used in rate development with contracting plans.</p> <p>Information and detail behind assumptions and data used in rate development should be provided to contracting plans in a timely manner with adequate time to meaningfully engage and respond to states about rate changes.</p>
Use of the +/-1.5 percent de minimis rate change as described in 42 CFR 438.7(c)(3)	<p>Provide clarification to states that the de minimis +/-1.5 percent as described in 42 CFR 438.7(c)(3) should be calculated based on the originally certified capitation rates for the effective period and not on the last approved revision of the capitation rates.</p>
Directed Payments	<p>Require states to provide contracting plans with the documents submitted to CMS including the pre-print, the supporting documentation, and the actuary’s statement that the rates are actuarially sound, as well as the reconciliation of the directed payments and what was originally assumed in the capitation rates absent the public health emergency.</p>
Retainer Payments	<p>Require states provide contracting plans the reconciliation of the retainer payments and what was originally assumed in the capitation rates absent the public health emergency.</p>
Risk Corridors	<p>Require states provide health plans with adequate notice of new risk corridors, providing sufficient time to meaningfully engage or respond to states proposals.</p> <p>Data should be made available and documentation provided in support of setting of/adjustments to risk corridors.</p> <p>Data/documentation availability should be in a timely manner.</p>