November 15, 2022

Mr. John Giles
Director, Division of Managed Care Policy
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Rate Setting Considerations – Actuarial Soundness & Transparency in Post-COVID-19 Pandemic/Public Health Emergency Planning

Dear Mr. Giles:

On behalf of the Medicaid Health Plans of America (MHPA), I would like to thank you and your colleagues from the Centers for Medicare & Medicaid Services (CMS)/Center for Medicaid and CHIP Services (CMCS) for your ongoing efforts in preparation for the unwinding of the COVID-19 public health emergency (PHE) to protect Medicaid beneficiaries from coverage loss or gaps that can have serious health consequences for populations that are particularly vulnerable. We greatly appreciate the partnership with CMS and states and remain ever ready as a continued resource to identify and implement best practices that ensure that individuals retain health coverage as the PHE comes to a close. As we continue to work together on post-COVID-19 PHE planning, we believe it is important to bring to your attention other issues that impact the Medicaid program and would like to raise several concerns related to the financial sustainability of the program with a focus on actuarial soundness, rate-setting, and transparency.

MHPA is the only national trade association with a sole focus on Medicaid, representing more than 130 managed care organizations (MCOs) serving more than 48 million Medicaid beneficiaries in 40 states, the District of Columbia and Puerto Rico. 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. 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.

MHPA believes that each state's efforts to ensure the sustainability of its Medicaid program should support the continued financial viability and stability of its partner MCOs. Specifically, MHPA supports adherence to two essential programmatic principles for states seeking to reduce Medicaid spending through their partner MCOs -- actuarial soundness and transparency. Statutorily mandated and codified in regulations, 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 promote Medicaid program

sustainability by ensuring adequate payments to safety net providers that facilitate beneficiary access to care as well as funding for important initiatives including those that advance health equity. The policies enable managed care partners to work with states to manage the risk of future health care costs. Ensuring transparency in the rate-setting process promotes active stakeholder engagement that supports greater clarity, the identification of issues, and better feedback.

As noted by the Kaiser Family Foundation, the COVID-19 pandemic "has profoundly affected Medicaid program spending, enrollment, and policy, challenging state Medicaid agencies, providers, and enrollees in a variety of ways."[1] We appreciate the efforts of CMS, and particularly 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. We understand that the COVID-19 pandemic will continue to impact Medicaid beneficiaries and the Medicaid program for the foreseeable future.

The capitation rate setting process is critical for ensuring that 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. As CMS continues to prepare for the unwinding of the COVID-19 PHE and looks to the future, we would like to take this opportunity to underscore the importance of 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 through a capitation rate setting process that is transparent and that supports rates that are actuarially sound.

The COVID-19 pandemic and the declaration of the PHE introduced considerable uncertainty related to the utilization of care and services and the impact of policy changes on future claims. With the resumption of redeterminations that will follow the end of the PHE, our member plans continue to work with CMS and their state partners to minimize coverage loss, but also recognize the potential for wide-scale coverage disruption and disenrollment. Looking back at the period of uncertainty defined by the pandemic, including the period impacted by redeterminations, we may find that assumptions used in establishing rates have been materially inaccurate. The potential risk to rate setting (and actuarial soundness) is further complicated and magnified by inconsistencies in approaches from state to state.

MHPA believes transparency is a critical safeguard in the rate-setting process. Ensuring transparency in the rate-setting process promotes active stakeholder engagement that supports greater clarity, the identification of issues, and better feedback. Transparency aligns with CMS's interests in the public availability of data that would allow for the evaluation and comparison of

[1] https://www.kff.org/medicaid/report/states-respond-to-covid-19-challenges-but-also-take-advantage-of-new-opportunities-to-address-long-standing-issues/

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states and delivery systems. And we note that in the June 2022 MACPAC report[2], the Commission's rationale for providing the opportunity for public input related to directed payments equally applies to the benefits of transparency in the rate-setting process.

While the COVID-19 PHE has illuminated the need for increased transparency in uncertain times, we also believe the benefits of transparency in the rate setting extends beyond the conclusion of the PHE and into a future period of status-quo rate development. Establishing a rate setting process that engages MCO involvement early allows us to be a more active and collaborative participant in the process.

Therefore, to support and build upon the success of state-managed care partnerships in the Medicaid program, MHPA respectfully requests that CMS review the following PHE-related and status quo rate development considerations to support the continued viability of state-Medicaid managed care partnerships and the long-term sustainability of the Medicaid program:

PHE-related Rate Setting Considerations

- *Short-Term: Provide up-front guidance on the technical in-year adjustments that states should prepare for with regards to redeterminations and PHE-specific assumptions.*

  We understand that prospective rate setting during the PHE is inherently a challenging exercise. The redetermination freeze has resulted in a beneficiary cohort that is difficult to predict and the uncertainty around the ending of the PHE and resulting redetermination timeline of individual states has increased uncertainty in the actuarial soundness of capitation rates. There is currently a very broad range of how state actuaries have approached these challenges, both in terms of how capitation rates are set and the actuaries' willingness to make mid-year adjustments to capitation rates when assumptions made in rate development prove to be wrong. PHE related variances to assumptions include: projected versus actual membership, case mix acuity, utilization, or the distribution of disenrollment impacts. We believe it is inconsistent with the intent of setting actuarially sound capitation rates to incorporate actual experience for the full benefit set in the last few months of the rating period. We request that CMS release prescriptive guidance to states and their actuaries on monitoring of PHE-related assumptions over the course of the redetermination period and the process by which actuaries should determine if an in-year rate adjustment is necessary. We are requesting that this guidance focus only on the assumptions related to the PHE given the extremely rare and nation-wide impact. We also reiterate that rates should retain their prospective nature, and while adjustments to specific assumptions may be warranted, overwriting the rates based on full actual experience late in the rating year essentially eliminates the full risk nature of capitation rates.

[2] https://www.macpac.gov/wp-content/uploads/2022/06/Chapter-2-Oversight-of-Managed-Care-Directed-Payments-1.pdf

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- *Short-term: Consider the impact of the PHE on the current risk adjustment algorithm.*

  Risk adjustment processes represent significant protection for MCOs against anti-selection in beneficiary selection. Generally these processes rely on enrollment at a specific point in time, often prior to the beginning of or early within the contract year. We expect a significant change in MCO membership profile during the months after the redetermination period, causing these enrollment snapshots to become a poor representation of the relative risk of individual MCOs. We request that CMS release guidance related to appropriate adjustments to risk adjustment algorithms that reflect the uncertainty of this process.

- *Short-Term: Update OACT assumptions.*

  While we understand rate setting is largely within state control, due to the unprecedented volatility in enrollment and utilization expected during the redetermination period, there is a significant risk that assumptions used in establishing rates will be materially inaccurate. We strongly recommend that CMS release guidance to states emphasizing best practices and expectations for rate setting transparency, monitoring, and remediation during the upcoming Medicaid eligibility redetermination period.

- *Short-Term & Status Quo: Preserve the integrity of risk-based managed care.*

  As noted previously, MHPA appreciates that CMS clarified its commitment to allowing only prospective risk-sharing arrangements within the Final Medicaid Managed Care rule. While we understand the PHE has been an unprecedented time and recognize that early in the pandemic states' need for flexibility was great; we encourage CMS to uphold its commitment to ensuring stability and validity of risk-based managed care by not allowing retroactive modifications or new retroactive risk-sharing arrangements once a contract period has begun.

- *Short-Term: Keep it simple - Leverage existing approaches.*

  As noted above, the dynamics of setting rates within this highly volatile environment is challenging. We believe that actuaries, states and MCOs have a variety of proven tools at their disposal to establish actuarially sound rates, manage to upside and downside risk tolerance, and reward quality. We ask that CMS heavily scrutinize any new mechanism or contract design that introduces complexity into the system during this already complicated rate cycle.

- *Short-Term: Keep risk sharing or financial calculations within a single contract period.*

  The bar for actuarial soundness is established on a single contract year. Provisions that seek to establish linkages between financial performance in closed contract periods and

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future rate periods can distort the actuarial soundness determination for the impacted rate period and inject greater volatility and uncertainty into the program. Additionally, such provisions limit health plans opportunities to invest in innovations, community partners, and capacity building as reserves must be held in order to prepare for potential recovery efforts in outyears of the multi-year arrangements.

Status-Quo Rate Development Considerations

As we move away from the PHE and re-establish a typical rate setting process, we respectfully request that CMS/CMCS consider encouraging state adoption of the following enhancements to each state's specific process:

- *Proactive communication with MCOs early in capitation rate development.*

  We would appreciate having early insights into key programmatic decisions being made by state Medicaid agencies, major methodological changes proposed by the state actuaries, and any material issues or concerns surrounding the program that have been identified. Involving the MCOs early in these conversations allows us to contribute valuable feedback we may have as the stakeholder with the most direct day-to-day contact with both Medicaid beneficiaries and healthcare providers. Further, this provides MCOs with a greater opportunity to align internal systems and processes to departmental goals prior to the beginning of a contract.

- *Enhance transparency of rate setting process that is consistent across states.*

  States and their actuaries should be transparent and forthcoming about all aspects of rate development that impact MCOs. Transparency should include having state actuaries review their assumptions with MCOs while remaining open to amending them based on the MCOs' more current experience. Additional recommendations include, but are not limited to:

  - Sharing the complete rate certification documents submitted to CMS
  - Providing logic and justification for "proprietary" calculations (e.g., underwriting gain)
  - Items that were analyzed and/or considered, but deemed immaterial to the final rate development

- *Increased documentation of the decision-making process.*

  We understand that rate development involves substantial consideration of various assumption scenarios and methodologies. However, MCOs frequently see only the end-result of the work of state Medicaid agencies in its actuaries. It would be beneficial to our

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organizations to more fully understand the considerations that go into individual rating decisions and the justifications used. We request that the actuarial certification includes a description of how a state's actuaries develop specific assumptions. Of particular importance is the development of service cost trends, so each individual organization can understand expectations of programmatic trends through the contract and benchmark internal results appropriately, and the development of projection assumptions related to programmatic changes, so organizations can ensure that we are aligned with the state in how we administer these changes.

- *Allow greater opportunity for MCO feedback during rate development.*

  We understand that capitation rate development is a long and complicated process which can encounter unforeseen obstacles. This was particularly true during the pandemic, as state Medicaid agencies needed to react to constantly changing circumstances. These delays often resulted in the window of time for MCO capitation rate and contract review to be dramatically shortened. We feel that these shortened review windows do not provide MCOs with sufficient opportunity to provide constructive and valuable feedback on assumptions made by actuaries. Any constructive feedback process should include a three-way dialogue between MCOs, the state Medicaid program, and the state's actuaries, which often cannot conceivably be accomplished in the window provided. Further, delays in receiving proposed capitation rates limits MCOs' ability to understand the financial implications of rate changes and project financial performance during the contract accordingly.

  We propose that the most appropriate way to allow for MCO feedback is to provide more frequent piecemeal updates to MCOs during the rate development process, such as with updates regarding base data development, service cost trends, and key programmatic changes. This can allow the MCOs and state actuaries to discuss these topics and limit the content that is unknown when capitation rates are provided to MCOs.

- *Provide an avenue for direct communication with CMS/CMCS.*

  We understand the significant effort currently undertaken between CMS/CMCS in the management of the State's Medicaid programs. It is often the case that a dialogue regarding significant programmatic decisions has been ongoing for months or even years prior to the involvement of managed care organizations. Given our unique proximity to both Medicaid members and provider networks, we frequently have operational or programmatic feedback regarding these changes. We believe a pathway directly with CMS to address these and similar concerns regarding specific assumptions that may jeopardize actuarial soundness, could benefit providers, enrollees, and the Medicaid program overall.

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Once again, thank you for your ongoing efforts to provide for a smooth transition from these COVID-19 policies that consider the long-term sustainability of the Medicaid program and for considering our recommendations. 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.

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

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