

March 20, 2023

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-10108
Mail Stop C4-26-05
Baltimore, MD 21244-1850

Re: PRA Notice, Medicaid Managed Care and Supporting Regulations; File Code CMS – 10108

Dear Administrator Brooks-LaSure:

On behalf of the Medicaid Health Plans of America (MHPA), I would like to thank you for the opportunity to provide comments for Paperwork Reduction Act Notice CMS-10108 surrounding risk corridor data collection efforts published in the *Federal Register* on January 17, 2023. Medicaid is the largest payer of health care in the United States and serves the most diverse population including children, adults, individuals with disabilities and the elderly. The COVID-19 pandemic underscored the Medicaid program's role as a critical lifeline for our nation's most vulnerable populations. Given the unprecedented nature of the COVID-19 pandemic, we appreciate efforts by the Centers for Medicare & Medicaid Services (CMS) to better understand how risk corridors were leveraged by states to reduce uncertainty surrounding utilization and health outcomes for individuals enrolled in Medicaid, especially considering the speed at which these provisions were put into place. Ensuring that data collection tools are standardized across states will facilitate a better understanding of how state approaches to risk mitigation during the COVID-19 pandemic differed, as well as how Medicaid managed care organizations (MCOs) performed during the public health emergency (PHE).

MHPA is the only national trade association with a sole focus on Medicaid, representing more than 130 MCOs serving more than 49 million Medicaid beneficiaries in 40 states, the District of Columbia and Puerto Rico. MHPA's members include both for-profit and non-profit, national, 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.

Our member plans are committed to collaboratively working with CMS and our state partners to learn from the challenges and best practices manifested by the COVID-19 pandemic. We are pleased to have this opportunity to provide the following comments:

Detailed Comments

1. Consider rate setting and existing risk mitigation arrangements as a whole

- a. Risk corridors operate in a complex actuarial environment and should be viewed in the context of other mechanisms and the full scope of rate setting arrangements unique to each state. The 2016 Medicaid Managed Care Rule requires that

capitation rates for MCOs be set such that the MCO would achieve a Medical Loss Ratio (MLR) of at least 85%, ensuring that Medicaid funding is spent appropriately. In addition, certain states require profit caps for Medicaid MCOs as well as requirements to reinvest revenue into infrastructure to promote access to care. Medicaid MCOs also make significant investments in addressing social determinants of health (SDOH) via value-added benefits and in lieu of services. These investments aid states in building provider capacity and help beneficiaries to stay healthier but are often administrative costs for health plans. Further, while we appreciate and applaud CMS for taking proactive steps to ensure that states and health plans were well positioned to meet the evolving needs of beneficiaries during the COVID-19 pandemic, the shifting regulatory environment resulted in an administrative burden for states and plans as they sought to maintain compliance with new flexibilities and requirements. The evaluation of MCO performance during the COVID-19 pandemic being limited to risk corridors and MLR performance does not fully capture the flexibility and adaptability of the managed care industry to the evolving needs of state partners, members, and providers. We recommend the inclusion of these additional elements outside of the risk corridor template for the results of this exercise to be informative for future policy recommendations. We welcome the opportunity to collaborate with CMS and stakeholders to ensure that this exercise captures the full actuarial environment of Medicaid managed care.

2. Need for clearer definitions on revenue/expenses with examples

- a.** Additional nuance and clarity surrounding this risk corridor template would improve CMS' ability to compare state approaches and the performance of Medicaid MCOs. Specifically, we ask that CMS provide additional clarity to states and MCOs on the definitions of plan revenues and expenses. Below we provide a few examples for how varying interpretations of actuarial definitions, risk mitigation arrangements, or differing market dynamics may impact the conclusions drawn by this data collection exercise.
 - i.** The data collection template is specific to one-sided, two-sided symmetric, or two-sided asymmetric risk corridors. However, many states included other COVID-related risk mitigation mechanisms and/or rate cuts to protect states from overfunding plans during the pandemic. These actions should be factored in when assessing performance.
 - ii.** Interpreting revenue and expense fields differently will lead to different results. Variation in how quality expenses, performance withholds, and treatment of sub capitated expenses are calculated can lead to inconsistency and may pose a challenge to comparing outcomes across states. Detailed instructions could provide additional clarification on what is expected to be included in those fields.
 - iii.** Claims runout included in the risk corridor will impact the calculation. Standardization of the runout period could provide consistency when measuring results. Some states that had risk corridors through December 31, 2021, may still be capturing runout.

3. Prospective Rate Setting

- a. Further refinement of this tool will improve its ability to study and improve risk corridor management in the future. As CMS seeks to gather information on these risk corridors, we continue to endorse a prospective rate setting process, as supported by previous CMS regulation and guidance. Prospective rate setting incentivizes cost containment, stabilizes state budgets through true transfer of risk, and reduces retroactive settlements to allow for more reliable financial reporting. We applaud CMS for working collaboratively with the managed care industry and state partners, which allowed us to collectively navigate the challenges of the COVID-19 pandemic. We ask for the opportunity to continue this collaboration in a transparent and comprehensive way as CMS seeks to evaluate the impacts of the pandemic and identify potential policy changes, including and especially those that could dramatically redefine the nature and level of risk in the Medicaid managed care program and associated level of participation by experienced and established carriers.

Since the beginning of the COVID-19 pandemic and the declaration of the PHE, MHPA has been committed to working with states and CMS to ensure that health plans continue to provide high quality health care to Medicaid beneficiaries during these unprecedented times. As mentioned above, our member plans are committed to continuing to collaboratively and proactively work with CMS and our state partners to learn from the challenges and best practices manifested by the COVID-19 pandemic.

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