November 1, 2024

Daniel Tsai, Deputy Administrator and Director, CMCS
John Giles, Director, Division of Managed Care, CMCS
Tristan Cope, Deputy Director, MMCEG, CMS
Centers for Medicare & Medicaid Services
Department of Health and Human Services

Re: Follow-up; Q3 2024 MHPA/CMS Meeting on Capitation Rate Setting

Dear Deputy Administrator Tsai,

On behalf of the Medicaid Health Plans of America (MHPA), we thank you for the opportunity to follow-up on our October 3, 2024 meeting with the Managed Care Group at CMCS and the Office of the Actuary at CMS, where we discussed capitation rate setting issues.

MHPA is the only national trade association with a sole focus on Medicaid, representing more than 150 managed care organizations (MCOs) serving nearly 47 million Medicaid beneficiaries in 40 states, the District of Columbia and Puerto Rico. MHPA's member plans 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.

Actuarial soundness ensures adequate funding is provided to Medicaid MCOs to manage risk for health care services and related administrative expenses. An actuarially sound 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.

MHPA is concerned that several factors, most notably shifting member acuity and trend predictability, are contributing to a unique environment creating significant rate pressures for states and health plans. Additional factors including data lag in rate development, program design changes such as gold carding, prescription drug policies, and regulatory pressures are exacerbating these challenges. The sustained underfunding conflicts with and undermines CMS' objective of improving access to services for those individuals.

In our letter below, we will provide detailed information on ongoing rate pressures as well as recommendations for CMS and states to alleviate the situation. **The recommendations are summarized here, and laid out in additional detail below:**

- ***CMS should release guidance to:***
  - ***Reinforce the need for mid-year rate adjustments;***
  - ***Encourage use of emerging data in rate setting;***
  - ***Position the final rates near or at the mid-point of the actuarially sound rate range.***

- ***Include tools or instructions in rate-setting guide to support states in accurately accounting for policies and program design changes.***
- ***Increase monitoring and transparency of rate setting.***
- ***Provide technical and analytical assistance for Medicaid State leadership for monitoring financial performance and program stability.***

Discussion Key Trends Impacting Rates

Acuity shifts in a post-unwinding environment

As states unwind flexibilities from the COVID-19 pandemic, rapid changes in the acuity of member pools have made it challenging to maintain adequate funding for the changing population over time. Although states may have completed their initial round of redeterminations in Q2 of 2024, plans continue to see membership volatility and changing acuity through the remainder of 2024.

Table 1 shows a specific health plan experience in one state through member Benefit Care Ratio (BCR), which is a ratio of medical costs to revenue, by stayers, leavers, joiners, and churners for the past four quarters. As you can see, the BCR of those staying is increasing – as is the BCR of the population that is leaving. This also demonstrates the significant costs associated with individuals who are joining the program today and churning, while revenue lags behind. As illustrated by Table 1, joiners are coming into plans with higher acuity, receiving services such as hospital stays, and are then leaving plans. Revenue is not adequately covering the services provided for these individuals. **Even after the completion of the 14-month PHE unwind process, MCOs are still observing material decreases in enrollment that exceed pre-unwind disenrollment levels.** MCOs appreciate the budgetary pressures facing our state partners and look forward to continuing to partner in a collaborative manner to meet the needs of Medicaid enrollees. However, despite these challenges, only a few states applied an adjustment for member churn due to the PHE unwinding, and many states did not apply adequate acuity adjustments in recently received capitation rates.

Table 1

BCR				
Row Labels	2023Q3	2023Q4	2024Q1	2024Q2
Stayer	84%	93%	93%	100%
Joiner	135%	140%	145%	123%
Leaver	80%	79%	75%	106%
Churner	*170%*	*133%*	*108%*	*139%*
Grand Total	**86%**	**94%**	**93%**	**101%**

Program design changes (Single PDL/PBM) for pharmacy benefit combined with hard to predict drug costs

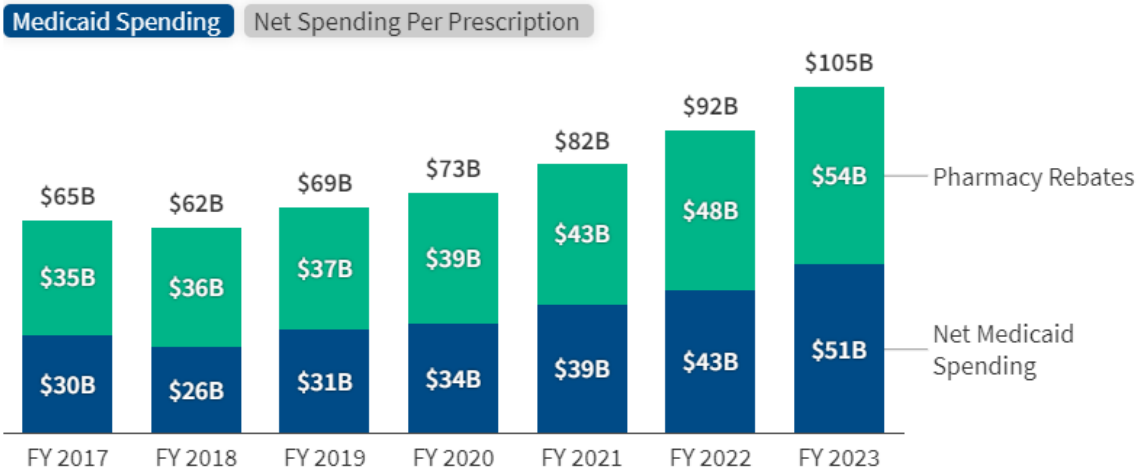
Prescription drug costs have become a major source of spending for state Medicaid programs. In fiscal year (FY) 2021 Medicaid spent $38.1 billion in net spending on prescription drugs. The Centers for Medicare & Medicaid Services (CMS) Office of the Actuary predicts the introduction of new drugs will push spending growth upward across payers from 2027-32.

KFF recently noted **net spending (spending after rebates) on Medicaid prescription drugs is estimated to have increased by 72%**, from $30 billion in FY 2017 to $51 billion in FY 2023, likely driven by the emergence of new high-cost specialty drugs.

Figure 2

Gross and Net Medicaid Spending on Prescriptions Drugs Have Increased in Recent Years

Medicaid gross spending, net spending, and rebates on outpatient prescription drugs, FY 2017 - FY 2023



Note: FY = Fiscal Year. Rebates include statutory rebates, state supplemental rebates, VBA rebates, rebates under the ACA offset, and rebates for opioid use disorder medication assisted treatment. For more information on how net spending is calculated see methods of Recent Trends in Medicaid Outpatient Prescription Drugs and Spending.

Source: KFF analysis of 2017-2023 State Drug Utilization Data and CMS-64 Financial Management Reports, September 2024. • Get the data • Download PNG

KFF

Simultaneously, single preferred drug lists (PDLs) and single pharmacy benefit manager (PBM) designs limit the MCOs' ability to effectively manage this benefit by restricting mechanisms like promoting generic drugs and other tools to contain costs. Direct-to-consumer advertising increases the likelihood of enrollees using brand name drugs in single-PDL/PBM states, which are significantly more costly. States adopt single PDLs in an effort to maximize federal and supplemental rebate dollars; however, **states are consistently underfunding programs with single PDL and PBMs.**

Trend Predictability - New population demand not accounted for in rates

As providers and health systems return to "normal" following the PHE, we are seeing an increase in provider capacity and the demand for health care services. This may be in part due to significant focus on workforce recovery and in part due to policy changes that have increased fee schedules, expanded provider types (family members as caregivers) or otherwise made the Medicaid program more attractive to providers. Simultaneously, consumers are utilizing more services – either previously unmet need and/or new health conditions. The increased utilization exceeds the utilization expected by increased acuity of the membership. There is also likely supply/demand interplay between provider access and utilization realized; however, the suite of program changes taken by states and federal governments to increase access has worked and appears to be contributing to increased utilization.

There has been a general underestimation of these utilization trends in the rates set for 2024, in part due to data lag.

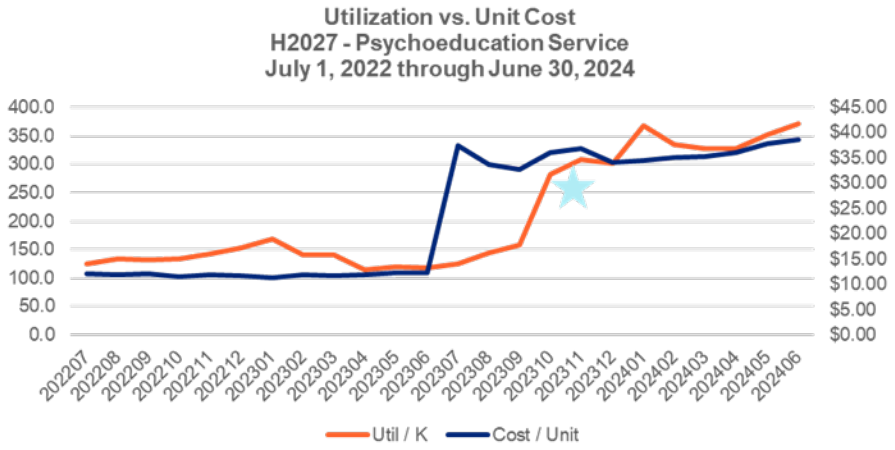
What follows are several examples from different states that underscore the efforts taken to increase access have resulted in more utilization. **To sustain access gains, we respectfully believe that states should accurately reflect the resulting increases in utilization in the MCO capitation rates in a more responsive and consistent manner.** We cannot as an industry sustain 4-5 years of significant program design change that stimulates utilization that is not supported by existing rates.

One plan reviewed core Medicaid members who have been enrolled with the plan since at least 2019. They saw increased access to services due to expansion of provider capacity over that time. For example: In one market the state increased its fee schedule by 40% for HCBS providers. This drove a corresponding lagged increase in utilization per thousand members of 14%.

In another state a 17% increase in fee schedule rates for Nursing Facilities (NFs)/Skilled Nursing Facilities (SNFs) resulted in a 39% increase in patients per thousand members.

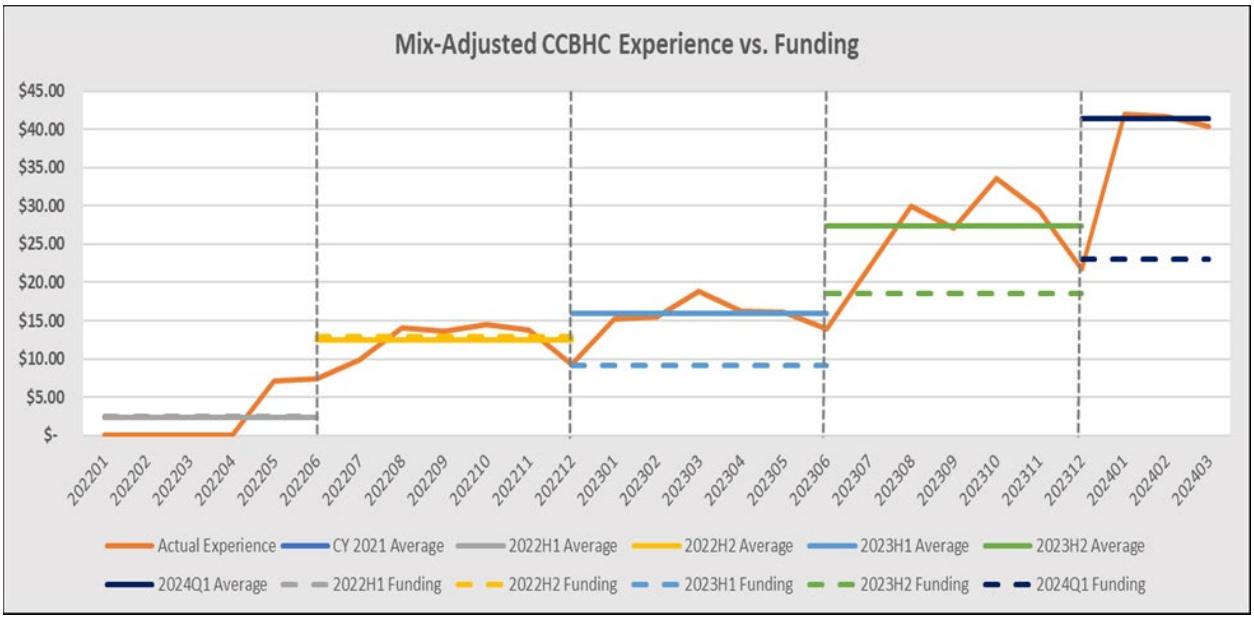
In another state, an actuarial analysis across plans analyzed Applied Behavioral Analysis (ABA) utilization for the period January 2022 – March 2024. The analysis, which was done using MCO data, shows utilization of ABA services increasing at an annualized rate of over 30%; and within child-only rate cells, growth is over 40%. While the fee schedule increase was included in the actuarial rate development, such a dramatic increase in utilization was not included. Figures 1 and 2, below, illustrate these examples.

Figure 1: State Example of Fee Schedule Increase and Subsequent Utilization for a Behavioral Health (BH) Code



NOTE: Fee schedule increase pre-dated a utilization per 1000 increase. The rate setting process accounted for the unit increase multiplied by historic utilization. However, the rate setting did ***NOT*** account for the jump in utilization that was a result of more provider capacity created by the fee schedule increase.

Figure 2: MCO Financial Impact Over Time of Fee Schedule Increases w/o sufficient corresponding rate increases



NOTE: Fee schedule increase and program implementation around Certified Community Behavioral Health Clinics (CCBHCs) has brought additional services to states. Unfortunately, the

above graph demonstrates the year-over-year (YOY) worsening of the disparity between actual health plan experience and funding.

It is also important to note that the increases in provider capacity are not happening equally throughout the states and we are not seeing corresponding decreases in other areas of spending (e.g. reductions in inpatient, emergency department use, etc.).

Inflationary Pressures

Inflationary pressures have not been captured in the rate setting process and contribute to unpredictability in trends. Although inflation has stabilized to 2.4% in September 2024 according to the U.S. Bureau of Labor Statistics, inflation in September 2022 was as high as 9.1% and remained at 4% in May of 2023. Because rates are set prospectively using baseline data from previous years, actuarial trending is not adequately addressing the short and long-term impact of recent high inflation years. This impacts both administrative and benefit costs for the MCOs.

Costs Associated with Regulatory Enhancements to Access and Quality

We applaud CMS for their recent actions to enhance access and quality for Medicaid enrollees, and look forward to partnering with states and the Administration to operationalize these changes. However, the additional regulatory factors from a high volume of recent rulemaking will require states, plans, and providers to make significant investments in areas such as network adequacy and technology to remain compliant with new requirements. Some of the more significant policy changes include:

- Requiring wait time standards for primary care, OB/GYN, BH, and one state selected service with secret shoppers to verify compliance.
- Requiring managed care plans to submit an annual payment analysis to states.
- State directed payments (SDPs): Average commercial rate provision and requirement that SDPs to be incorporated into Medicaid managed care capitation rates.
- Establishing a Medicaid and CHIP quality rating website and implementation of a mandatory measure set.
- Requiring that states ensure that 80% of Medicaid payments be spent on compensation for direct care workers.
- Requiring minimum nurse staffing levels at long-term care facilities.

What is on the horizon to create future pressure in 2025?

PHE/Redetermination impacted base data is the source for prospective rate setting. All three completed years necessary for 2025 rate setting were substantially impacted by COVID and PHE continuous eligibility. Due to the significant environmental and marketplace changes during the past 4 years, simply trending forward pre-pandemic or mid-pandemic utilization patterns does not accurately account for the current design of the program, provider rates or behavior patterns or the Medicaid population health needs. ***In addition to leveraging 2023 data to establish rates, we***

encourage the consideration of emerging 2024 utilization data for 2025 rates given the significant shift in acuity and utilization this year.

Significant program design changes have already been implemented and more policies designed to increase access and make serving Medicaid more attractive are planned for 2025- 2030. ***We must accurately, consistently, and expeditiously account for changes that will impact utilization patterns in prospective rate setting.*** As recent rulemaking by CMS is implemented, having stability in the program and adequate rates is more important than ever as states and MCOs need to make investments to be prepared for new requirements. If we do not account for the behavior change induced by these changing policies, the industry will be perpetually underfunded. (Figure 2 demonstrates how lagged rating drives perpetual underfunding and instability)

Actuarial soundness requires capitation rates to provide for all reasonable, appropriate, and attainable costs, ***including administrative expenses***. Our analysis of 2024 and draft 2025 administrative funding reveals that overall, 2025 administrative funding is projected to be significantly lower. This decrease is attributed to significant losses in member volume that were not adequately offset by an appropriate economies of scale adjustment (i.e., fixed cost leveraging). Additionally, there are several enhanced requirements at the state and federal level that require additional administrative resources for successful implementation.

Actions CMS and States can take to stabilize the Medicaid program and rate setting

- ***Release of guidance for reinforcing the need for mid-year rate adjustments.***
    - We encourage CMS to provide states with guidance laying out the various options available to them for adjusting rates based on trends, acuity, and the other factors laid out above.

- ***Provide guidance to encourage use of emerging data in rate setting***
    - We encourage CMS to include in the above guidance best practices and tools for leveraging current emerging data in rate setting, in light of the current dynamic environment post PHE.

- ***Provide guidance to position the final rates near or at the mid-point of the actuarially sound rate range.***
    - Due to all the considerations discussed above, there has been a material mismatch between key pricing assumptions and emerging actual experience. On top of this, the wide range of key assumptions has caused additional pricing pressures due to the fact that in many states the final rates are positioned near or at the bottom of the rate range. MHPA highly recommends that CMS issue policy guidance to require/encourage positioning the final rates at or near the mid-point of a rate range until experience stabilizes.

- ***Include tools or instructions in rate-setting guide to support states in accurately accounting for policies and program design changes*** intended to increase access (e.g.

provider fee schedule increases, single PDL/PBM design, prior authorization/gold card, payment policy, network design requirements) that will likely cause changes in utilization.

- ***Increase monitoring and transparency of rate setting.***
    - Ensuring transparency in the rate-setting process, including contract and rate renewals, promotes active stakeholder engagement that supports greater clarity, the identification of issues, and better feedback. Proactive communication and ongoing dialogue throughout the rate-setting process can also support efficiencies. MHPA has consistently advocated for transparency between States and MCOs in the rate setting process, going back to comments on the 2020-2021 Medicaid Managed Care Rate Development Guide. MHPA encourages adoption of the following safeguards to support consistency and transparency throughout the rate-setting process:
        - Proactive communication with MCOs early in capitation rate development.
        - Allow greater opportunity for MCO engagement and active participation throughout the rate development process.
        - Increased documentation of the rate setting decision-making process.
        - Furthermore, it is critical that CMS monitor trends and acuity on an ongoing basis to ensure that rates continue to be actuarially sound, so that adjustments can be made when utilization is not reflecting the assumptions made during rate development. Health plans have made significant efforts to work with states to address these concerns through mid-year adjustments, with little success.

- ***Provide technical and analytical assistance for Medicaid state leadership for monitoring financial performance and program stability.***
    - It is critical that states monitor trends and acuity on an ongoing basis so that adjustments can be made when utilization materially deviates from assumptions made during rate development. Many Medicaid Agencies have lost staff capacity, historic knowledge and programmatic expertise following the PHE. High turnover has created shifts in the roles, processes and procedures state agencies have in place to monitor rates, health plan sustainability and anticipate program shifts. While contracted actuarial firms support rate development, it is expected that Medicaid agencies have consistent reviews and monitoring in place to identify early deviations from actuarial assumptions. CMS could enhance the technical assistance provided to states and reinforce the need to have processes, procedures and tools in place to consistently monitor program efficiency and stability.

Once again, thank you for the opportunity to provide a follow-up after our Q3 call on October 3, 2024. We believe that adequate, current, and actuarially sound rates in Medicaid support access to care and services for Medicaid beneficiaries. We appreciate the opportunity to share our perspective on addressing these challenges and look forward to continuing to work with CMS and our state partners to make a meaningful difference in the lives of Medicaid beneficiaries.

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
Senior Vice President, Government Relations, Policy & Advocacy