AHIP Detailed Comments on CMS Proposed Rule

Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care [CMS–2408–P]

1a. Actuarial Soundness Standards –
Option to Develop and Certify a Rate Range (§ 438.4(c))

In the 2016 Medicaid Managed Care Final Rule, CMS required states to certify and obtain CMS approval of specific managed care rates within each rate cell, beginning with rate periods on or after July 1, 2018. The 2016 Final Rule prohibited the use of rate ranges, a method by which states formerly would obtain approval for a range of possible rates that they could apply to managed care contracts. CMS now proposes to partially undo the 2016 change by giving states an option to certify a range of capitation rates of up to 5 percent for each rate cell. This option is subject to certain requirements and an actuary must certify that the upper and lower limits of the proposed range are actuarially sound. States must provide and justify data, assumptions, and methodologies used to derive the upper and lower bounds of the rate range; and provide criteria for paying rates at different points within the range. In addition, states electing this option would have to submit rates and certifications to CMS prospectively, in advance of the start of the rating period.

AHIP has serious concerns with this proposal. Although a limited range of 5 percent is a significant improvement over rate ranges in use in some states under prior guidance, we believe the proposal to return to rate ranges harms the transparency and integrity of the rate setting process. Further, as noted by CMS when it eliminated rate ranges in the 2016 rule, rate ranges are inconsistent with rate setting practices for non-Medicaid health plans. We believe rate ranges increase the risk that Medicaid managed care plan payment levels will be set at levels that are not actuarially sound as required by statute, thereby jeopardizing the ability of plans to deliver care coordination, disease management, and other necessary coverage and services.

We understand CMS may be proposing to reinstate the rate range option because states maintain that they need the rate range flexibility in competitive bidding. However, even without the proposal, states would still be able to develop rate ranges for use in evaluating bids. They would need to have completed the final rate ranges prior to the bid process and made available to MCOs prior to the bids being due to ensure an independent process. Rate ranges should not be directly developed retrospectively from bids that reflect incomplete data, but rather they should be developed prospectively from a state actuary's robust data set. Final CMS review and approval is critical given recent examples in several competitive bid processes. For example, competitive bids in Kentucky in 2011 resulted in a severely underfunded program with one Medicaid managed care organization (MCO) terminating its contract in the first two years of the program, creating confusion for members and issues with continuity of care. Similar situations have played out in other states, including Illinois, Iowa, Minnesota, and New Hampshire.

Rate ranges undermine actuarial soundness in several ways:

- Actuarial experts in our member Medicaid plans are concerned that a 5 percent range is too wide for rates to be actuarially sound at the high and low ends. That is particularly the case given that state actuaries do not consistently set a "best estimate" at the middle of their rate range. For example, if the best estimate is set at the high end of the rate range,

the proposal would allow state actuaries to set the low end of the range as much as 5 percentage points below the "best estimate" that would most likely reflect revenue requirements for plans. This reduction is material and would undermine the goals of actuarial soundness and financial stability.

- Some states supply only limited, summarized data to MCOs in competitive bidding processes, with insufficient detail for proper bid development. Further, state Medicaid Request for Proposal (RFP) timelines often do not allow sufficient time for review and/or discussion of the state's data in detail to allow MCO actuaries (who may be unfamiliar with a new program) to prepare and certify rates without qualification. Thus, even though a plan's bid may fall within a rate range, the rate stemming from that bid may in fact not be actuarially sound for that plan based on additional data and other information unknown to the plan. We believe this is a particular risk in competitive bidding processes, where financial pressures may make it difficult for state actuaries not to accept an MCO bid in the range even if the state actuary would otherwise have approved a higher rate based on the information available to the state actuary.
- If CMS were to permit limited rate ranges, it is important to note they may be more appropriate in some cases and less appropriate in others. We can see some argument for a limited rate range in newer programs or populations for which claims experience is not available and there is a greater chance of inaccurate assumptions. However, we still believe rate ranges are unnecessary in such cases, especially when rate ranges are derived from competitive bid amounts. Existing guidance allowing a 1.5 percent adjustment up or down without additional CMS review and the ability to use risk sharing mechanisms can address these issues. Conversely, we see no justification for a 5 percent range or variations in base rates for mature, established programs where underlying trends and assumptions should be well known when rates are established.

Given the foregoing factors, we strongly recommend that CMS not adopt its proposal to reinstate rate ranges in competitive bid procurements, keeping in mind that states still retain the flexibility to vary rates by 1.5 percent without requiring additional certification or approval. We believe this is most consistent with the statutory actuarial soundness requirement.

Furthermore, if CMS moves forward with the proposal to reinstate rate ranges, we believe significant modifications would be needed to provide even minimum assurances that resulting rates would be actuarially sound. For example:

1. The definition of the rate and ranges should be clarified to exclude inclusion of any pass-through payment amounts.
2. CMS should consider a narrower rate range of 2 percent or two times the underwriting gain reflected in the rate calculation, whichever is less.
3. Rate ranges should not be permitted in mature programs where utilization patterns and costs are generally stable and familiar to stakeholders, and trends and assumptions should be well known.
4. States using rate ranges in competitive bidding should be required to provide MCOs with rate ranges that will be used to evaluate plan bids, detailed trends, and historical cost data in advance of bidding, increasing the likelihood that bids will be more likely to result in

actuarially sound rates. We note that state data books provided to plans may include significant amounts of information; however, the information they contain is not exhaustive. State actuaries have access to more program information than do MCOs when states release competitive bids. In the absence of complete information, MCOs can misprice program bids and lock themselves into rates that later prove to be inadequate to fund the program.

5. Some states historically have sought to use rate ranges to modify capitation rates during the contract year in response to state budgetary actions that are unrelated to changes in Medicaid scope of services, administrative responsibilities, or costs of care. For example, state legislatures have passed legislation that requires the state Medicaid agency to reduce MCO rates by an arbitrary amount, but with no underlying benefit, program or other cost structure changes that support the reduction. Therefore, we support the elements of CMS' proposal that require states certifying a rate range to document the capitation rate changes, prior to the start of the rating period, for the applicable MCO at points within the certified rate range consistent with the state's criteria in proposed paragraph (c)(1)(iv); and to require CMS approval of subsequent changes, with the changes limited to addressing errors in how criteria were applied, errors in data, assumptions or methodologies, and program changes. While we view requiring submission of rate ranges in advance of the rating period as a positive element, we note that MCOs should have time to review proposed ranges before they are finalized and sent to CMS.
6. We urge CMS to engage directly with MCOs, e.g., through a technical expert panel, in addressing these issues and developing appropriate standards and clarifications.

1b. Actuarial Soundness Standards –
Capitation Rate Development Practices that Increase Federal Costs and Vary with the Rate of Federal Financial Participation (FFP) (§ 438.4(b)(1) and (d))
CMS proposes to modify certain provisions of § 438.4(b)(1) to clarify that differences among covered populations in the assumptions, methodologies, and other factors ("Rating Factors") used by states to develop MCO capitation rates must be based on valid actuarial rate development standards representing actual cost differences in providing services to the different populations. Further, CMS proposes to specify in § 438.4(b)(1) that any differences in Rating Factors used to develop capitation rates may not vary with the Federal Financial Participation (FFP) associated with the covered populations in a way that would increase federal costs. Effectively this provision would apply to Medicaid expansion populations (and potentially CHIP programs), which have higher rates of FFP than TANF (Temporary Aid for Needy Families), ABD (Aged, Blind, and Disabled), and LTSS (Long-Term Services and Supports) populations.

Under proposed § 438.4(d)(1), several Rating Factors—related to margins, provider reimbursements and medical loss ratio (MLR) remittances—are identified as violating this standard if they vary by populations with different FFPs. The proposal also indicates this list in 438.4(d)(1) is nonexclusive; other practices could be impermissible if they vary by FFP in a way that would increase federal costs.

We have a number of serious concerns with this proposal. Actuarial principles and sound rate development practices sometimes require the variation of rate assumptions consistent with the characteristics of different Medicaid populations and the programs in which those population are

enrolled, and it is not always appropriate to use the same assumptions for all population types. Those actuarial principles and practices apply without regard to the FFP involved.

While we appreciate that the proposal allows cost differences to support different Rating Factors across populations, we are concerned that the language separately prohibiting different Rating Factors across populations with different FFPs will be confusing to states and MCOs. In particular, it is unclear whether CMS intends to prohibit different Rating Factors between expansion populations and other populations, or whether CMS is merely intending to prohibit different Rating Factors only for particular costs (margins, provider payments, MLR remittances) that CMS believes should not vary by population. It is critical that CMS clarify this point, as the uncertainty may make it difficult for actuaries to sign unqualified actuarial statements of opinion (actuarial certifications) in some cases.

As noted above, our view is that a total ban on different Rating Factors for expansion populations, without allowing for actual cost differences, would violate actuarial standards of practice. Accordingly, we urge that CMS clarify that Rating Factors, other than those specified in 438.4(d)(1), can vary across populations with different FFPs.

In addition, we are concerned that the language in 438.4(d)(1) would provide a non-exclusive list of prohibited practices. This could create ongoing uncertainty about rate development practices. We believe the regulation should instead specify practices that are proscribed. If over time CMS identifies additional rate development components that it believes also should not vary across populations with different FFPs, the agency should propose to eliminate them through formal notice and comment rulemaking.

Beyond these general concerns, we note the following issues with CMS' proposal to limit or prohibit certain established actuarial practices in § 438.4(d)(1):

- **Variation by Margin – § 438.4(d)(1)(i)**

We are concerned about the assumption underlying the proposal: that it is inappropriate for margin percentages to vary across populations. Such variations may exist for entirely reasonable and appropriate actuarial reasons that are unrelated to the level of FFP.

From an economic perspective, the cost of capital should increase consistent with the level risk of the project in which the capital is invested. In Medicaid managed care, risk increases in proportion to the level of uncertainty regarding the accuracy of the assumptions used in the rate development. Uncertainty for a given population may arise from various factors, such as the absence of a coverage history, recent or likely legislative changes, instability in enrollment, inconsistent state capitation rate payment patterns, incomplete information on trends, and/or the introduction of new treatments with unknown utilization patterns and significant unit costs. Sound actuarial practice dictates that it is often appropriate to build in higher risk margins for this uncertainty.

We also note that differences in risk can apply between TANF, ABD, and LTSS populations even though they have the same level of FFP. Since the assumptions in these lower FFP programs may vary, it is not even clear what risk margins would be used for the comparison with

the higher FFP expansion population. For example, would CMS require that expansion population risk margins be no greater than a combined risk margin for other populations? We do not believe it would be reasonable or appropriate to require such a comparison. Risk margins for individual populations should reflect the risk associated with that population.

We have concerns that the proposed language fails to account for other complexities in rate setting. For example, there may be risk sharing arrangements in a contract, such as risk corridors, MLR guarantees and net income limits, that lower or raise risk for a given population. These factors would have to be considered in any comparison across populations. Further, different populations may have significantly different PMPM costs. Therefore, the same absolute risk margin when measured against different costs can result in different margin percentages.

For example, LTSS populations have relatively high PMPM costs and less membership volatility than expansion populations. Higher risk margins for expansion populations would be appropriate to reflect the relative risk associated with the enrollees, and when measured against a smaller PMPM cost, could result in a larger profit margin as a percentage of premium. Disallowing such reasonable variation could lead to inappropriate cost subsidization across populations.

Therefore, we recommend that CMS not broadly restrict variation by margin for risk and contingency in this section (i.e., profit margin or operating margin). Instead, states should have the ability to incorporate appropriate risk charges that reflect different levels of risk across populations.

However, if CMS were to finalize this provision, we suggest that the agency at least clarify the terms referring to "margin" to avoid potential confusion. *Actuarial Standard of Practice (ASOP) 49*[1] requires that Medicaid rate development include an "underwriting gain" in the capitation rates. The underwriting gain is comprised of two components: the "cost of capital" and a "margin for risk or contingency". The proposal uses several terms related to margin – "profit margin", "operating margin", and "risk margin" – and does so interchangeably, even though these concepts may not always have the same meaning and may be subject to different interpretations by different stakeholders. CMS should consider removing the terms "profit margin", "operating margin", and "risk margin" from this section of the rule and substitute the term "margin for risk and contingency" to be consistent with *ASOP 49*. In addition, or as an alternative to this approach, CMS should consider convening an actuarial work group composed of state Medicaid and Medicaid MCO actuaries to develop appropriate definitions and inform CMS guidance on this rating factor.

- **Variation by Fee Schedule – § 438.4(d)(1)(ii)**

CMS also proposes to restrict states from including different costs for providers in developing Medicaid expansion capitation rates if those cost differences derive from fee schedules that are higher than fee schedules for providers in the TANF, ABD, or LTSS programs, since Medicaid expansion programs receive a higher FFP. In our view, this would be a significant change from traditional funding approaches.

[1] See Section 3.2.12(b) *Actuarial Standard of Practice (ASOP) 49 – Medicaid Managed Care Capitation Rate Development and Certification*; Actuarial Standards Board; accessed Dec 21, 2018 http://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf;

We are concerned that excluding consideration of cost impacts of different fee schedules in rate development may hamper the ability of MCOs and states to recruit and contract with certain kinds of provider networks, such as behavioral health, to meet CMS requirements for network access and adequacy. In certain cases, providers may not agree to Medicaid's lower fee schedule rates, and Medicaid budgets would be adversely impacted by adopting higher fee schedule rates across the program. Further, MCOs in some states are contractually obligated to pay state-mandated fee schedules. As proposed, the regulation would allow states to continue to mandate fee schedules for various population types, but the Proposed Rule appears to exclude recognition of the differential costs of those mandated fee schedules in the capitation rates. MCOs would be forced to assume all the risk associated with these fee schedules, which would not be sustainable.

For the reasons noted above, we strongly believe CMS should withdraw this provision from the Proposed Rule and that states should be permitted to account for the impacts of varying fee schedules on Medicaid rates. However, if CMS was to retain the proposal to restrict states from accounting for different costs of different provider fee schedules in setting rates, to ensure actuarial soundness and program viability the Final Rule would need to restrict the ability of states to mandate provider fee schedules that vary by population type.

- **Variation by MLR Threshold – § 438.4(d)(1)(iii)**

CMS proposes in this provision to restrict states from using a lower MLR remittance threshold for the higher FFP expansion population compared to other populations, presumably since states need to return more of the remitted funds to CMS for expansion enrollees. We have several concerns with this proposal:

1. Expansion populations may require different MLR targets and therefore different remittance thresholds than other subpopulations to appropriately reflect different claims costs and administrative requirements unrelated to FFP. For example, a state obtaining a waiver for community engagement requirements for expansion enrollees may want to allow for higher MCO administrative costs and a lower remittance threshold for that population compared to a population with relatively high claims costs and comparatively lower administrative costs, such as the ABD population. Therefore, actuarial soundness could be compromised if states are required to assume the same MLR remittance thresholds across populations.
2. Even if CMS were to implement a rule tying MLR targets for the expansion population to other populations, we understand that some states currently use different MLR thresholds for their TANF, ABD, and LTSS contracts. For example, TANF populations naturally have lower MLR targets than LTSS and ABD, since they tend to have lower claim costs as a percent of the total capitation rates than the LTSS and ABD populations. It is unclear how CMS intends this proposal to operate in that case, but if some type of average MLR remittance threshold is envisioned, it may be impractical to calculate and, in any case, would not seem to be actuarially justified. Conversely, we are concerned the proposal could force MLR targets across populations to converge, which could ultimately lead to rates that are not actuarially sound.
3. The proposal also does not appear to account for recent statutory changes made by § 4001 of the *SUPPORT for Patients and Communities Act,* which allow states to retain a larger share of the remittances they collect from MCOs by remitting funds for expansion

enrollees at the state's standard rate of FFP, provided that certain conditions are met. We believe the impact of this change should be considered and guidance released for comment before CMS adopts new restrictions in this area.

In light of these concerns, AHIP recommends that CMS not finalize the limitations proposed in § 438.4(d)(1). We believe they will inhibit the ability of actuaries to include the valid assumptions needed to develop actuarially sound rates and could lead to inappropriate cross-subsidization across populations in some cases. We also note that some states have used different managed care programs for different populations and geographies that may be administered by different state agencies. The proposals could impose complexities and burdens in these states as different components may have to coordinate and negotiate Rating Factors with each other and with MCOs across the different programs. Finally, we believe the proposals are unnecessary, as CMS would retain the ability to question inappropriate assumptions and methods in its review of rates and can act to mitigate inappropriate methods when needed. However, we reiterate that if CMS does finalize the proposals relating to margins and provider payments, we urge CMS to adopt the specific recommendations included above.

2a. Special Contract Provisions Related to Payment –
Delivery System and Provider Payment Initiatives Under MCO, PIHP, or PAHP Contracts (§ 438.6(a) and (c))

Current rules at § 438.6(c)(1)(iii) allow states to direct certain provider payment arrangements in their contracts with MCOs relating to minimum fee schedules, pay increases, and maximum fee schedules. CMS proposes to add a specific category of directed payment arrangements involving minimum fee schedules based on state plan-approved rates, and to add a definition for such rates.

AHIP understands the need for state flexibility in directed payment arrangements. Medicaid MCOs carry out a key role on behalf of states in supporting stable provider environments for Medicaid enrollees, and directed payments are one tool that helps achieve that stability. However, we believe a further clarification is required in this section. Specifically, § 438.6(c)(1)(iii)(C)—which becomes § 438.6(c)(1)(iii)(D) in the proposal—allows states to adopt maximum fee schedules "…so long as the MCO, PIHP, or PAHP retains the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract." While CMS did not explain in the preamble why this caveat was added only in this provision, we believe the need for and ability of MCOs to manage risk effectively and have discretion in managing their contracts is not limited to maximum fee schedules. It is critical that MCOs have these abilities in any directed payment arrangement, including those that promote access and quality. Accordingly, we request that CMS clarify that MCOs' management of risk and their discretion in managing contracts should apply to all the directed arrangements enumerated in § 438.6(c)(1).

In addition, in the preamble to the 2016 Medicaid managed care rule, CMS recognized the need for MCO input in these arrangements. Responding to comments that additional requirements be added to 438.6(c), CMS noted that "Each state's Medicaid managed care program is unique, and the states are best positioned, *in collaboration with managed care plans and stakeholders*, to design delivery system reform efforts. Therefore, we decline to specify particular initiatives through regulation." (Emphasis added.) CMS understood that MCO and stakeholder input is

critical to achieving effective delivery system and provider payment initiatives. Accordingly, we urge CMS to codify its intentions by clarifying the need for MCO input in the regulation.

2b. Special Contract Provisions Related to Payment –
Risk-Sharing Mechanism Basic Requirements (§ 438.6(b))

CMS proposes in § 438.6(b)(1) to limit states' ability to add, modify, or remove any risk sharing arrangements after the start of the contract period. We appreciate CMS' efforts to support the evolution toward prospective certification, review and approval. However, we note that there are some circumstances in which a new risk sharing arrangement or a modification to an existing arrangement may be warranted for implementation during a contract period. Additionally, we are concerned that removing this option will increase program costs, as states would lose the ability to mitigate new risks that only become apparent during the contract period.

For example, when the new hepatitis C drugs were introduced in 2014, CMS issued guidance indicating that states were required to cover the drugs for their Medicaid enrollees. The significant costs of the new therapies were not contemplated in the capitation rate development for that benefit year, so some states elected to create new risk sharing arrangements during the contract period to limit the risk to the MCOs. Given the speed with which expensive new drugs, new technologies (e.g., Chimeric Antigen Receptor (CAR) T-cell therapy) and/or expanded treatment options (e.g., IMD services to address a substance abuse epidemic) are introduced in our health care system, states and MCOs will continue to have legitimate needs to implement or modify risk-sharing arrangements mid-contract.

Moreover, it may be appropriate for states to add risk-sharing mechanisms when unanticipated adverse case-mix scenarios arise. For example, coverage of certain drugs used to treat hemophilia can be problematic because there are relatively few enrollees in need of treatment and the treatment are extraordinarily costly. If a disproportionate share of these enrollees is inadvertently assigned to one MCO relative to other MCOs, concentrating treatment costs in a way that was not anticipated in the prospective rates, it may be appropriate to add a risk pool mechanism if an adequate risk adjustment system is not available in the state.

Therefore, we recommend that CMS withdraw this proposal from the Final Rule. CMS should instead permit retroactive, mid-year changes to risk-sharing arrangements when warranted by specific developments that reasonably correlate with significant cost impacts on scope or cost of services, subject to the rate re-certification process in § 438.7(c)(2). This would allow states the flexibility to address unexpected program and population issues that come to light after the release of capitation rates and which cannot be addressed with either rate cells or risk adjustment. In addition, CMS should consider convening a work group of consisting of CMS, state, and MCO actuarial experts to develop a common framework and guidelines regarding appropriate circumstances and processes for making such retroactive adjustments, in keeping with principles of program integrity and actuarial soundness.

2c. Special Contract Provisions Related to Payment –
Pass-Through Payments Under MCO, PIHP, and PAHP Contracts (§ 438.6(d))

CMS proposes to add § 438.6(d)(6), which would permit states to require Medicaid plans to make pass-through payments for up to three years to contracted network hospitals, nursing

facilities, or physicians when Medicaid populations or services are initially transitioning from a Medicaid fee-for-service (FFS) delivery system using supplemental payments to a Medicaid managed care delivery system, provided that certain requirements are met.

As we have noted in prior comments, AHIP continues to have significant concerns with a Medicaid structure that only permits pass-through payments in the context of FFS arrangements. We believe parity on this issue between FFS and managed care is critical so that states can choose the approach that best meets the needs of their citizens without arbitrary distinctions. That said, we do appreciate steps CMS has taken in the past to smooth out some of the disparate impacts of this unequal structure, including allowing a transition period away from pass-through payments for states already using managed care.

Accordingly, we appreciate the addition of this proposal to give additional states using supplemental payments the flexibility to provide for pass-through payments on a transition basis if they now choose to move their FFS programs to managed arrangements offering more effective care management and coordination. However, based on experience with the existing pass-through payment transition process, member plans note that it takes time for MCOs to work with providers to transition pass-through arrangements to other payment methods tied to utilization or quality. We believe that in many cases three years would not be enough time to work with providers to help them transition to alternative systems. Therefore, we recommend that CMS extend the transition period from three to five years in the Final Rule.

3. Rate Certification Submission (§ 438.7)

CMS proposes to revise § 438.7(c), relating to increases or decreases in Medicaid MCO capitation rate cells by up to 1.5 percent without submitting a revised rate certification, by specifying that adjustments would be subject to the requirements at § 438.4(b)(1). These provisions require that rates are developed in accordance with standards specified in §438.5 and generally-accepted actuarial principles and practices, that proposed differences among capitation rates according to covered populations are based on valid rate development standards, and that different rates among populations not be based on FFP. CMS also proposes at § 438.7(e) to provide at least annual guidance on standards, documentation and the review process for Medicaid capitation rate development. And finally, CMS proposes to give itself authority to require a state to provide documentation for adjustments to ensure that 1.5 percent changes to final certified rates comply with contractual standards for rates in § 438.3(c), covered service requirements in § 438.3(e), and actuarial provisions in § 438.4(b)(1).

AHIP supports CMS' intention as described in the preamble that rate changes permitted under § 438.7(c) maintain actuarial soundness and the integrity of the rate-setting process. While we believe the proposals help to achieve those goals, we believe additional changes are needed in § 438.7(c) to ensure those goals can be attained.

As CMS notes, the provision in the 2016 Final Rule permitting changes of plus or minus 1.5 percent in approved rates without recertification was based on the view that the resulting range was generally not more than the risk margin used in the rate development processes in most

states.[2] However, a study by the Society of Actuaries published in 2017[3] reached a different conclusion, finding that in many states this range actually exceeded risk margins. Therefore, to better ensure actuarial soundness and the integrity of the rate setting process, and ensure the regulatory standard is consistent with a key assumption upon which it is based, we recommend that CMS revise the rule so that the allowed percentage variance without recertification is limited to the lesser of: 1) the amount of risk margin included in the rates being adjusted; or 2) the limit of plus or minus 1.5 percent.

Additionally, we recommend two clarifications to this provision. First, the rule should specify that the 1.5 percent range is based on the original rate certified by CMS for that time period. Second, this limit relating to rate changes, including our proposed risk margin component, should be defined in terms of "percentage of premium" to eliminate ambiguity and ensure consistent definition and consistent application of the requirement. For example, assume approved rates for a given MCO in a state includes a risk margin of 1.0 percent that is expressed as a percentage of claim cost. Further assume claims costs equal 90 percent of premiums. Our recommendation is that the risk margin be expressed as 0.9 percent of premium, and the maximum adjustment would be 0.9 percent of premiums (the lesser of the risk margin or 1.5 percent of premium).

We also understand that states sometimes make program, benefit, fee schedule, and/or policy changes during the contract year which the state considers *de minimis,* and therefore make no change in rates. However, if a state exercises the flexibility in § 438.7(c) to adjust rates, we recommend that CMS require that the state either document that there are no additional changes during the year that created additional costs in the rates but were deemed *de minimis,* or take the additional uncompensated costs into account in determining the effective impact of the § 438.7(c) adjustment and the overall actuarial soundness of the rates.

In addition, while CMS' intent seems clear based on the proposed changes to this section and the preamble language, to eliminate any confusion, we recommend that CMS clarify § 438.7(c)(3) by stating explicitly that any adjustments made to capitation rates under the rules of this section must be actuarially sound. We also recommend that CMS require some form of documentation supporting the reason for the rate adjustment by removing the words "may require" and replacing them with "requires." We understand that state actuaries have such information readily available, so costs of providing documentation would be negligible. This change would still allow states to avoid a full recertification process, consistent with the goal of § 438.7(c)(3). At the same time, it can have a sentinel effect in ensuring states consider the critical issue of actuarial soundness whenever rate changes are made.

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[2] Medicaid Managed Care Final Rule, CMS-2390-F, *Federal Register,* Vol. 81, No. 88, May 6, 2016, page 27568; Centers for Medicare and Medicaid Services

[3] "Medicaid Managed Care Organizations: Considerations in Calculating Margin in Rate Setting," American Society of Actuaries, March 2017; accessed at https://www.soa.org/research-reports/2017/medicaid-margins/

With respect to the proposed addition in § 438.7(e), we appreciate CMS' commitment to providing additional guidance on standards, documentation, and the review process for Medicaid capitation rate development. Such guidance can help support the goals of the program and principles of actuarial soundness by addressing emerging issues and clarifying ambiguities that may arise as a result of new programs, benefits, technologies, or legislation. In addition, broad distribution of such guidance would promote general transparency and program stability.

MCOs would welcome CMS guidance on rate setting topics such as: value added benefits, both state-mandated and MCO-initiated; modification of MCO rates without corresponding changes in benefits or scope of services; alignment of rates with population risk; ensuring that contractual withholds, penalties, and sanctions are consistent with requirements that rates provide for all reasonable, appropriate, and attainable costs; the respective roles and responsibilities of states and CMS in certifying, reviewing, and approving capitation rates; and guidelines for the range and level of detailed documentation in state rate setting packages, including trends, assumptions, and utilization and cost data.

In addition to topics that CMS decides to address, we recommend that CMS also include a method for soliciting stakeholder input, in advance of the guidance, on topics to be addressed. For example, 60 days prior to planned issuance of new guidance, CMS could request that interested stakeholders submit suggested topics for discussion and/or guidance, with at least a two-week response period. CMS could then review the suggested topics and determine what to include in its new guidance.

In summary, with respect to rate certification submission provisions in § 438.7, we recommend that CMS make the following changes:

1. Revise this section so that the allowed percentage variance without recertification is limited to the lesser of 1) the amount of risk margin included in the rates being adjusted; or 2) the limit of plus or minus 1.5 percent;
2. Describe the permitted range of adjustment in terms of a percentage of the originally certified and approved premium to ensure consistent definition and consistent application of the requirement;
3. Require that states document that there are no changes during the year that created additional costs in the rates but were deemed *de minimus,* or take the additional uncompensated costs into account in determining the effective impact of the § 438.7(c) adjustment;
4. Update § 438.7(c)(3) to state explicitly that any adjustments made to capitation rates under the rules of this section must be actuarially sound;
5. Require documentation supporting the reason for the rate adjustment by substituting the word "requires" for the phrase "may require"; and
6. In advance of providing its additional guidance, solicit stakeholder input on other topics for discussion or clarification in the guidance.

4. Medical Loss Ratio (MLR) Standards – Technical Correction (§ 438.8)
CMS proposes to revise § 438.8(k)(1)(iii) by replacing "expenditures related to activities compliant with § 438.608(a)…" with "fraud prevention activities as defined in 438.8(e)(4)," consistent with corresponding changes in the 2016 Final Rule. CMS also proposes to correct a technical error in paragraph (e)(4) by replacing the phrase "fraud prevention as adopted" with the phrase "fraud prevention consistent with regulations."

AHIP appreciates CMS' attention to making these proposed clarifications and corrections in the MLR provision of the managed care Proposed Rule. In addition to these proposed clarifications and corrections, there are several other issues described below relating to the MLR provisions that we recommend CMS address when it finalizes the Rule.

- **Expenditures for Fraud, Waste, and Abuse**

As noted in the Preamble to the Proposed Rule, CMS proposed in 2015 to require Medicaid MCOs to submit data on their expenditures for fraud, waste, and abuse prevention activities described in § 438.608(a) for inclusion in plan MLR calculations. However, CMS did not finalize the proposal in the 2016 Final Rule and instead decided that Medicaid plan expenditures on fraud prevention activities would, for purposes of calculating MLR, be handled consistent with standards for the private market at 45 CFR part 158 and be incorporated into the Medicaid MLR calculation in the event the private market MLR regulations were amended.

Over the past few years, CMS has expressed an interest aligning regulatory policies across government health programs. Since the 2016 Final Rule was finalized, CMS modified Medicare Advantage plan MLR provisions to include plan expenditures on fraud reduction activities in the numerator of the calculation.[4] Because the Medicaid MLR standards remain tied solely to the individual market rules, Medicaid plan MLR calculations are now out of alignment with the MLR calculations for Medicare Advantage plans. We believe that fraud reduction efforts are critical across federal programs, and Medicare and Medicaid plan MLR calculations should be handled in a consistent manner. We urge CMS to revisit this issue in the Final Rule and take the steps necessary to align the Medicaid MLR formula with the Medicare Advantage formula with respect to expenses for prevention of fraud, waste, and abuse.

- **Expenditures on Social Determinants of Health (SDOH)**

CMS, states, and Medicaid MCOs have increasingly recognized the importance of SDOH on Medicaid enrollees, and the implications of SDOH for enrollees' health status and utilization of services. Secretary Azar noted in November 2018 that HHS is exploring how it could experiment with allowing health plan payments for non-health services like housing and nutrition. Further, states are building SDOH identification and mitigation strategies into their Medicaid managed care programs. For example, as part of North Carolina's new Medicaid managed care waiver approved by CMS in October 2018, Medicaid MCOs will screen every Medicaid enrollee for access to food, stable housing, and transportation as part of their initial assessment, and make referrals to community agencies. MCOs have been building these kinds of community partnerships, as well as evolving their value-added benefits to meet the social needs of their enrollees through programs focused on specific SDOH like food insecurity, physical activity, transportation, and housing.

[4] See 42 CFR 422.2430(a)(4)(ii)

We believe that recognizing these kinds of expenditures in the MCO MLR calculations would encourage greater investment and favorably impact overall program expenditures. Therefore, we recommend that CMS consider allowing the cost of value-added benefits and activities that target specific SDOH to be included in the numerator of Medicaid MCO MLR calculations. This would encourage more spending on items that would help the overall health of the beneficiaries and lower overall program costs for federal and state payers.

5a. Information Requirements – Language and Format; Taglines (§ 438.10(d))
In response to concerns over enrollee confusion and increased document length, CMS proposes to relax requirements for the use of taglines as well as the font size for taglines. Instead of requiring taglines on all written materials, CMS will require taglines only on materials for potential enrollees that "are critical to obtaining services." The second change proposed by CMS is to remove the requirement for "no smaller than 18-point" font and instead adopt the "conspicuously visible" standard codified at 45 CFR 92.8(f)(1). Preamble language from the Proposed Rule implementing the "conspicuously visible" standard indicates it means content is "sufficiently conspicuous and visible that individuals seeking services from, or participating in, the health program or activity could reasonably be expected to see and be able to read the information."

AHIP supports this proposal. We believe it is a measured and appropriate approach that will increase the readability and effectiveness of documents, allow for continued use of shorter but effective communication formats, and reduce unnecessary administrative burdens.

While we are very supportive of these changes, we believe additional clarity on these standards would be helpful, particularly in the Medicaid context, to promote a common understanding and reduce the risk of extreme variations for defining and utilizing the "conspicuously visible" standard from state to state.

5b. Information Requirements –
Language and Format; Provider Termination Notices (§ 438.10(f)(1))
CMS proposes to change the current regulatory requirement that MCOs issue notices to enrollees within 15 calendar days following receipt or issuance of a provider's termination notice. Under the proposal, notices to enrollees would be required by the later of: (i) 30 calendar days prior to the effective date of the termination; or (ii) 15 calendar days following receipt or issuance of the provider notice. The change recognizes it may not be uncommon that a provider termination notice is issued initially, but ultimately the provider and MCO reach agreement and the provider remains in the MCO's network.

AHIP supports the proposed change. We commend CMS for acknowledging operational realities that may affect the contracting process and agree that eliminating unnecessary termination notices will reduce enrollee confusion.

5c. Information Requirements –
Language and Format; Provider Directories § 438.10(h)(3))
CMS proposes to modify the requirements related to provider directories by eliminating the "completion of cultural competency training" data element. AHIP appreciates and supports the

proposal. It aligns Medicaid managed care rules with the FFS standards for cultural competency included in the 21st Century Cures Act.

In addition, CMS proposes to reduce the frequency for updating and re-printing paper directories from monthly to quarterly for MCOs using mobile-enabled electronic directories. AHIP also supports this change. It reflects the significant strides AHIP member plans have made in effectively using mobile-enabled directories. Such directories allow network changes to be reflected more timely and allow enrollees to access information in real time as opposed to waiting for delivery of more cumbersome and costly printed provider directories.

Because mobile-enabled electronic directories are a fast and cost-effective way to provide up-to-date information to enrollees, AHIP requests that CMS further limit the need for automatically sending printed provider directories to enrollees and allow Medicaid MCOs to distribute printed provider directories only upon request.

6. Network Adequacy Standards (§ 438.68)

Since issuing the 2016 Final Rule, CMS indicates it has heard from states that there are a variety of challenges presented by utilizing time and distance-based standards for ensuring network adequacy. CMS notes telehealth as one service type for which time and distance cannot appropriately reflect the adequacy of the network, and LTSS as a service type for which time and distance standards are not effective measures. The proposal also acknowledges the practical challenges in using a single type of network adequacy measure in different states with unique geographies and local conditions. To address state concerns, CMS proposes to relax the time and distance requirement and allow states the option of setting quantitative minimum access standards for certain health care and LTSS providers.

AHIP strongly supports this change. We believe this added flexibility will support states and MCOs in pursuing innovations through the use of telehealth and other emerging technology-based tools. We also strongly support CMS' encouragement of stakeholder input in development of standards, possibly through use of a technical expert panel or advisory group. We believe that meaningful MCO involvement, combined with appropriate CMS guidance, is critical to ensure, among other things, that MCOs are able to implement those measures effectively.

7. Enrollee Encounter Data (§ 438.242(c))

CMS rules at § 438.242(c)(3) currently require that MCOs submit to states all enrollee encounter data that states are required to report to CMS under § 438.818. CMS proposes to specify that the "allowed amount" and "paid amount" are included in the list of required encounter data elements. CMS notes the proposal would not change the rights of federal or state agencies using data for program integrity purposes, nor change disclosure requirements for enrollee explanation of benefits (EOB) and other coverage notices.

As CMS indicates in the preamble, Medicaid health plans view their contractual payment rates and terms with providers as confidential and trade secret information, the disclosure of which would potentially harm the competitive positions of both plans and providers. However, we also understand the need for such information in achieving the goals of the Transformed Medicaid Statistical Information System (T-MSIS) program and how such data can support the

development of informed state and federal Medicaid budgeting and actuarially sound rates. We appreciate CMS' assurance that competitive data will be protected from disclosure and suggest that CMS reinforce this assurance by including with the definition an affirmative statement such as "subject to applicable federal and state confidentiality laws and regulations."

We also note that CMS currently provides limited definitions of the "allowed amount" and "paid amount" terms.[5] Given the variety of contracting and subcontracting arrangements and to ensure that data collected are as uniform as possible, we recommend that CMS provide more guidance on these definitions and seek input from MCOs and other stakeholders on the proposed clarifications. Without specific definitions for the data collected that accommodate the range of potential payment arrangements (including capitation case rates), information received by CMS may lack uniformity and comparability, and fail to provide an accurate picture of enrollee encounters.

8. Medicaid Managed Care Quality Rating System (§ 438.334)

The Quality Rating System (QRS) framework included in the 2016 Final Rule gives states the option to either use a framework developed by CMS or establish a state-specific system producing substantially comparable information about plan performance. Recognizing the challenges associated with creating a comparable system across states given the extent of customization and variation among state Medicaid programs, CMS proposes to require that a state alternative system produce information that is substantially comparable to the CMS-developed framework to the extent feasible, taking into account differences in state programs that complicate achieving comparability, such as covered populations, benefits, and stage of delivery system transformation. CMS would engage with states and other stakeholders in developing sub-regulatory guidance on this comparability standard. CMS would also specify certain mandatory measures, to which states would be able to add measures. Finally, CMS proposes to modify the current regulations, which require alignment with summary indicators between a Medicaid/CHIP QRS and a rating system, to provide that (i) such alignment is required "where appropriate," in recognition of the different populations served by MCOs in Medicaid and CHIP; and (ii) alignment is also required with other CMS quality rating systems where appropriate.

AHIP supports CMS' overall approach of aligning a minimum set of measures while allowing states to specify additional measures to address certain state areas of concern. However, we have noted several areas with concerns and recommendations:

- Medicaid MCOs will be responsible for contracting with providers and developing the various processes needed to implement the QRS. Medicaid MCOs have significant experience with quality rating systems in other programs. Therefore, it is critical that Medicaid MCOs have an opportunity to play a meaningful role in the development of all aspects of the QRS framework, such as the timeline, measures selection and retirement, reporting mechanism, minimum sample size, display and description of results. We believe significant input from Medicaid MCOs is necessary to ensure the system provides for appropriate metrics that facilitate useful comparisons, incentivize desired goals, and

[5] We understand that the T-MSIS data dictionary defines the "allowed amount" as the maximum amount determined by the payer as being 'allowable' under the provisions of the contract prior to the determination of actual payment, and the "paid amount" as the total amount paid on a claim or adjustment at the claim detail level.

minimize provider burdens. We recommend that CMS establish a working group that brings together experts in quality measurement from Medicaid health plans and other stakeholders to assist CMS in developing a robust and effective Medicaid QRS. Further, we strongly recommend that that CMS consider developing the overall framework and measure set in conjunction with the Core Quality Measures Collaborative (CQMC), in which CMS is a partner along with AHIP, the National Quality Forum, and many other key national quality authorities and stakeholders. The CQMC seeks to identify high-value, scientifically robust measures for adoption across payers to provide consumers with consistent information for making healthcare choices while minimizing provider impacts.

- CMS should develop a framework of Medicaid QRS principles—and share those principles with stakeholders for comment—to guide how measures will be selected for and retired from the QRS. This would be similar to the approach the agency adopted for Star Ratings in the Medicare Advantage program and the CMS Meaningful Measures Initiative framework. Alternatively, CMS could leverage principles of the CQMC as a foundation for the Medicaid QRS. Medicaid QRS principles should ensure, for example, that proposed measures: are evidence-based and endorsed by a recognized quality standards organization; aligned across programs to the extent feasible, emphasizing measure sets like the Medicaid Adult and Child Core Sets; and incorporate methodologies and time frames with which plans and states have experience. In addition, principles should ensure that measure sets are balanced with respect to both the kinds and number of measures.
- CMS indicated that when a state chooses its own QRS, the state would have to seek CMS approval only if requested by CMS. AHIP recommends that CMS require all states to receive prior approval of proposed additional measures. Advance CMS approval is necessary to ensure states are implementing useful and meaningful measures that align with CMS principles and minimize provider burden. CMS also might use an intermediate approach that would recognize certain other endorsed measures as appropriate for Medicaid and aligned with CMS objectives, in addition to core Medicaid measure sets. States choosing these measures would have deemed approval to use them in an expanded state QRS.
- In addition to seeking advance approval for the QRS, states proposing to use non-validated measures as a part of their QRS should be able to do so only if the measure is evidence-based, reliable, valid, and meets at least one of the following criteria: endorsed by a consensus-based entity; developed under a contract or other arrangement with the Secretary in accordance with the CMS Measure Development Plan; or otherwise determined by CMS to be evidenced-based, reliable, and valid. Furthermore, states should be required to test non-validated measures and present at least a year of data to demonstrate the measure's validity and usefulness before the measure is fully implemented in the QRS.

9a. Grievance and Appeal System – Statutory Basis and Definitions (§ 438.400)

CMS proposes to modify the definition of "adverse benefit determination" in an effort to clarify when an MCO is required to send a notice of an adverse benefit determination to an enrollee. CMS notes that some MCOs are issuing notices of adverse benefit determinations for every denied claim, including claims that are denied for purely administrative reasons but which

generate no financial liability for the enrollee. CMS recognizes that notices in these cases can create administrative and economic burdens on plans and unnecessary confusion and anxiety for enrollees. To eliminate these unnecessary notifications, CMS proposes to add language stating that a denial of payment for a service because the claim does not meet the definition of a clean claim at § 447.45(b) is not an adverse benefit determination.

AHIP strongly supports the intent of CMS' proposed change but we believe that further clarification is necessary to ensure uniformity in interpretation. Medicaid MCOs indicate that there are instances where certain received claims might be interpreted by states or MCOs as technically meeting the "clean claim" definition but which must be denied for administrative reasons such as provider billing errors. Since denials in these cases do not generate financial liability for enrollees, some states reasonably interpret existing rules as not requiring notices of adverse benefit determination to avoid the same confusion, anxiety and burden CMS seeks to eliminate in its proposal. We are concerned that the clean claims provision, if adopted as proposed, could inadvertently cause confusion in day-to-day operations as states and MCOs attempt to determine how to apply notice requirements in these potentially ambiguous cases.

To allow states and Medicaid MCOs to comply more effectively with CMS' intent to limit the instances in which enrollees without financial liability receive unnecessary notices of adverse benefit determinations, AHIP proposes that CMS strike the proposed clean claim language and instead specify more directly that notice requirements are not triggered in situations where a member will be held harmless or is not financially responsible despite a full or partial denial of a payment for service.

Alternatively, CMS could provide additional context for the definition of "clean claim" by including guidance and a range of practical examples. The examples should make clear that the notices are not triggered in the denial cases mentioned in the preamble such as missing data or duplicate submissions, nor are they triggered in other similar cases such as clear billing errors or practices involving waste or abuse. Either change would still provide for independent determinations on the need for notices at a later point, e.g., after a resubmitted claim, if an enrollee could then be subject to financial liability.

9b. Grievance and Appeal System – General Requirements (§ 438.402)

In an effort to reduce barriers experienced by enrollees who wish to appeal an adverse benefit determination, reduce burdens, and expedite appeals, CMS proposes to eliminate the requirement added by the 2016 Final Rule for enrollees to submit a written, signed appeal after an oral appeal is submitted. Managed care plans would otherwise be required to treat oral appeals in the same manner as written appeals.

AHIP appreciates and supports this change. We agree with the effort to reduce burdens placed on enrollees and plans. However, eliminating the written appeal requirement raises one practical concern. If an enrollee expresses the desire to appeal a determination to a community-based employee of the MCO (e.g., community outreach worker or HCBS service coordinator), it may be difficult to ensure the appeal is appropriately registered with the MCO on a timely basis and ensure that the issue being appealed is characterized correctly. Accordingly, we recommend that

CMS allow plans to require that an oral appeal be made to the MCO's appeals and grievances department to ensure appropriate, accurate, and timely documentation and handling.

9c. Grievance and Appeal System – General Requirements (§ 438.406)
In the 2016 Final Rule, CMS extended the timeframe for requesting a state fair hearing to 120 calendar days. We agree with the concerns acknowledged by CMS that the change, which created different deadlines for managed care and FFS services, has created a variety of unintended challenges for enrollees, states and MCOs. CMS proposes to modify the 2016 rule by requiring states to allow enrollees no less than 90 calendar days and no more than 120 calendar days to request a state fair hearing. This would allow states who wish to align timeframes in their managed care and FFS programs to do so while allowing states that have changed their standard to 120 calendar days to maintain their approach.

While AHIP agrees with CMS' intent to allow for alignment of managed care and FFS timeframes, we do not support the proposal and recommend an overall limit of 90 calendar days. We believe the benefits of such alignment, including minimizing confusion and administrative costs, and encouraging more timely resolution of cases, outweigh any state interest in maintaining a longer timeframe.

10. CHIP Requirements (§ 457, Subpart L)
In the Proposed Rule, CMS clarifies the application of updates of the Medicaid managed care rule to CHIP, including network adequacy standards, MLR standards, QRS and other quality standards, appeals and grievances, and requirements for beneficiary information. The Proposed Rule also addresses CHIP-specific technical and clarifying edits, in areas such as appeals and grievances, sanctions, and program integrity safeguards. AHIP agrees with these clarifications and supports the alignment of CHIP with Medicaid managed care whenever reasonably feasible. Opportunities for alignment allow for streamlining and more effective use of MCO resources.

AHIP is concerned, however, that CMS has not proposed to apply the Medicaid actuarial soundness requirements to CHIP. Instead, CMS is retaining the general requirement for actuarial soundness in CHIP rates codified at 42 CFR 457.1203. AHIP requests that CMS reconsider this position. Actuarially sound rates are a cornerstone of successful Medicaid managed care programs. The more detailed procedural requirements for actuarial soundness in the Medicaid regulations offer important protections for the expenditure of state and federal dollars and ensure MCOs can effectively offer their enrollees the full range of benefits and services. Different rate setting processes in CHIP also can create silos between the two programs that can add unnecessary administrative burdens in tracking separate processes.