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January 14, 2019

Mr. John Giles
Medicaid Managed Care Operations
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services (HHS)
Attention: CMS-2408-P
Baltimore, MD 21244

Re: Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care; Proposed Rule File Code CMS-2408-P

Dear Mr. Giles:

On behalf of the American Academy of Actuaries[1] Medicaid Subcommittee, I appreciate the opportunity to submit comments on the November 14, 2018 proposed rule regarding the Medicaid and CHIP programs.

Summary of the Proposed Rule

From the November 14, 2018, Federal Register: "This proposed rule advances CMS' efforts to streamline the Medicaid and Children's Health Insurance Plan (CHIP) managed care regulatory framework and reflects a broader strategy to relieve regulatory burdens; support state flexibility and local leadership; and promote transparency, flexibility, and innovation in the delivery of care. These proposed revisions of the Medicaid and CHIP managed care regulations are intended to ensure that the regulatory framework is efficient and feasible for states to implement in a cost-effective manner and ensure that states can implement and operate Medicaid and CHIP managed care programs without undue administrative burdens."

While not as comprehensive as the May, 2016 Medicaid and CHIP Final Rule (2016 Final Rule), the Notice of Proposed Rulemaking (NPRM) CMS-2408-P document (including the preamble) contains material breadth and depth. With 60 references to variations of "actuary/actuarial" and another 100+ references to "capitated/capitation," the subcommittee limited the items on which it chose to comment to those most relevant to actuaries . Hence most of our comments or questions have been grouped under "Setting Actuarially Sound Capitation Rates" (see November 8, 2018 CMS "Fact Sheet" Topics), "Special Payment Provisions", and generally "Other". With Final Rule dates of 2002, 2016, and presumably 2019, there is a chance Medicaid and CHIP programs will operate under this eventual Final Rule for a decade or more. With that possibility, we offer

[1] The American Academy of Actuaries is a 19,500 member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

an additional section requesting consideration and/or reconsideration of items we have labeled "Next Generation".

References

While the subcommittee members relied upon their individual and collective expertise, and a combined multiple decades of experience in Medicaid and CHIP managed care actuarial rate-setting and other actuarial issues, three source documents were often utilized in the development of our comments and questions below, and are listed here:

- Final Rule: Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability 05/06/2016 https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered

- 2018-2019 Medicaid Managed Care Rate Development Guide https://www.medicaid.gov/medicaid/managed-care/downloads/guidance/2019-medicaid-rate-guide.pdf

- Actuarial Standard of Practice (ASOP) No. 49 "Medicaid Managed Care Capitation Rate Development and Certification" http://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf

General/Miscellaneous Comments

- The Subcommittee[2] supports necessary capitation rate development transparency and documentation requirements. With the CMS-2408-P NPRM, CMS has made several positive policy advances in this regard.

  We once again ask that CMS consult with states and their health plan partners to consider the amount of lead time necessary for state programs and actuaries to implement any changes necessary to comply with the final new rules. The rate-setting process begins approximately 12 months prior to the contract effective date, and material changes would lengthen that timeframe, especially in the initial year.

- The total associated cost and burden to states and their staff of the 2016 Final Rule, and the CMS-2408-P NPRM are, however, of significant concern - just as we raised in our comments back in 2015[3]. The details of the Final (and proposed) rule, and associated sub-regulatory requirements, suggest that a considerable amount of additional staff resources, time, and money will be needed in order to comply with the rule as written. This cost and

[2] http://www.actuary.org/committees/dynamic/MEDICAID
[3] http://www.actuary.org/files/Academy_Comments_on_Medicaid_NPRM_7_27_15.pdf

burden is not consistent with 2019 and beyond actual costs to states (i.e., state budget realities), and the additional funding required should be addressed by CMS/HHS.

- The Subcommittee's comments reflect our recognition that health plan-employed actuaries and state-employed actuaries, understandably, have different perspectives (e.g., the appropriateness of capitation rate ranges). Each group or individual brings valuable experience, expertise, and perspective to any discussion, and CMS should carefully consider each perspective, whether contained within this letter or elsewhere, as it finalizes Medicaid managed care rules and regulations.

Key Actuarial Issues

Although the detailed comments and questions on the proposed rule can be found below, we have summarized key actuarial issues.

- CMS proposal concerning Federal Financial Participation (FFP) impact on rating components may be overly restrictive with respect to justifiable, sound actuarial rating assumptions;
- CMS-proposed approach to rate range certification and width might not be viewed favorably by states and their actuaries, who may not believe it provides states the flexibility needed to efficiently administer their programs or health plans and their actuaries who believe the allowed width is too wide;
- Implementation of Directed Payments and Pass-through Payments in capitation rates;
- Next generation rate-setting around social determinants of health as well as payments by a state to a health plan based on value or outcomes instead of volume (as recorded by claims or encounter data) should be addressed; and
- Formal review of a health plan's operating needs should not be part of a capitation rate withhold analysis.

Setting Actuarially Sound Capitation Rates

Section 42 CFR 438.4(b)(1) and (d) FFP rate variation

We recognize CMS' concerns with rate variation by FFP and the potential impact on the federal budget. Moreover, we agree that the factors used to develop rates must be based on valid rate development standards "that represent actual cost differences in providing covered services to the covered populations."

However, we also recognize that there could be valid actuarial reasons to vary rating components such as margin, reimbursement, and /or minimum medical loss ratio (MLR). A few examples are provided below:

a. *Margin for a new program*: It is not uncommon to temporarily elevate the risk margin for a new program to recognize the increased risk of mispricing the program, especially where the base period data is not available, not fully credible, or requires adjustment. The new program could be of any FFP level.

b. *Population size*: It may be appropriate to have a higher margin or lower minimum MLR for a small program/population that may be subject to more variation. An example might be a program for children who have medically complex needs.

c. *Reimbursement*: It could be appropriate to assume, or have the state direct, higher reimbursement where it is difficult to recruit providers. One example is dental services in general, and in particular dental for individuals with disabilities, who might require specialized services or providers and who may be chronically underserved as a consequence.

d. *High premium populations versus. low premium populations*: High premium populations, such as disabled or long-term services and support (LTSS) populations, will tend to have lower variation as a percent of premium. These populations might therefore appropriately have a lower margin as a percent of premium. Often they also have lower administrative costs as a percentage of premium, which means higher target/pricing medical loss ratios. Coincidentally, disabled or LTSS populations are also those that are likely to have the lowest average rate of FFP, as they have little or no Affordable Care Act (ACA) Expansion, CHIP, or family planning exposure. The proposed regulation could have the unintended consequence of causing states to increase margin or reduce minimum MLR requirements for their disabled or LTSS populations, to the extent that those margins or MLRs are not appropriate for lower premium populations, such as Section 1931 low income families.

In addition, we are concerned that the list of prohibitions for capitation rate development practices could limit states' abilities to negotiate programmatic initiatives (social determinants of health, provider contracting arrangements, etc.) designed to benefit covered populations. States should continue to be allowed to be flexible/nimble in how they organize their Medicaid and CHIP programs, and we have concerns that this provision could impede that work.

We recommend that CMS reconsider using a list of rate development practice prohibitions and instead maintain the requirement that states provide supporting evidence for any differences of factors. This allows states to maintain flexibility and ownership in guiding their Medicaid and CHIP programs to best support their beneficiaries and ensures that actuarial soundness requirements for individual rate cells, as required in §438.4(b)(4) and (5), can be met. With those significant concerns and recommendations in mind:

1. Please confirm that the proposed restrictions on margin in §438.4(d)(1)(i) refer to margin only ("profit margin, operating margin, or risk margin") and do not apply to other non-benefit cost components.

2. Please clarify whether margin in §438.4(d)(1)(i) was intended to be quantified as a percentage, a per member per month (PMPM), or using another basis.

3. Lowest average FFP: As written, the proposed regulation compares each population or contract to the population or contract with the lowest average FFP, with no comparison between other programs.

4. Please clarify the application of this section to contracts that include blended Medicaid and CHIP populations, which would result in a higher average rate of FFP than the standard state rate.

Section 42 CFR 438.4(c) Option to Develop and Certify a Rate Range

§438.4(c) provides an option for states to develop and certify a rate range per rate cell within specified parameters. We note that there is not consistent agreement among actuaries regarding certification of actuarially sound rate ranges. For example, it is our understanding that many state-employed actuaries prefer the flexibility of actuarially sound rate ranges while many health plan-employed actuaries do not believe rate ranges are appropriate. With this being noted, following are some specific comments regarding the provisions of §438.4(c):

- §438.4(c) requires that the upper bound of the rate range does not exceed the lower bound of the rate range multiplied by 1.05 (a 5% limit). We note that an actuary would typically consider many factors (e.g., maturity of the program, credibility/quality of the base data, amount of statistical variability in the underlying claim distribution, size of the population, etc.) in order to determine the width of an actuarially sound rate range. Some actuaries would prefer less restriction and more flexibility in their ability to create rate ranges greater than 5%, while other actuaries are concerned that the 5% range is too wide.

- §438.4(c) requires that the rate certification documents the state's criteria for paying managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), or prepaid ambulatory health plans (PAHPs) at different points within the rate range. It would be helpful if CMS could provide clarification regarding criteria deemed acceptable for paying health plans at different points within the rate range. For example, is it only acceptable for states to vary rates between health plans based on cost differences in providing covered services to the covered populations, or could rates vary based on a negotiation or a competitive bidding process?

- §438.4(c) requires that states using the rate range option in §438.4(c)(2) would not be able to modify capitation rates within the plus or minus 1.5 percent range allowed under §438.7(c)(3). This does not appear to provide the intended additional flexibility under the rate range option because recertification and resubmission of rates would be required for minor changes that occur to the program after the rate development work and certification is completed, creating additional administrative burden on states. CMS should consider approaches to integrate the +/- 1.5% option into the capitation rate range. One approach would be that the capitation rate range be either increased or decreased by a value reflective of the policy change up to +/- 1.5% from the initial certification rate range.

- §438.4(c) requires states wishing to modify the capitation rates within a rate range during the rating year to provide a revised rate certification demonstrating that the criteria for initially setting the rate within the range, as described in the initial rate certification, were

not applied accurately; that there was a material error in the data, assumptions, or methodologies used to develop the initial rate certification and that the modifications are necessary to correct the error; or that other adjustments are appropriate and reasonable to account for programmatic changes. This does not appear to provide the intended additional flexibility under the rate range option because recertification and resubmission of rates would be required for minor changes that occur to the program after the rate development work and certification is completed. For example, would CMS consider allowing flexibility within + / - 1.5% of the selected rates within the range, as they allow for states that don't set a rate range?

- We recommend that CMS include in §438.4(c) a statement that the application of approved risk adjustment methods could result in the rates being paid to a particular health plan being outside – either below or above – the rate range being certified. We would recommend that CMS allow for a non-budget neutral risk adjustment process when the certifying actuary has developed a capitation rate range. The certifying actuary would need to document the normalized or 1.00 risk base; however, the resulting payment may result in an increase or a decrease in the overall capitation rates, for example, if health plans bid at different rates within the range.

- Certain government-mandated costs vary by health plan and should be considered outside of the rate range. For example, the Health Insurance Providers Fee (HIPF) for fee years 2020 and beyond will, under current law, vary from zero for certain health plans to as much as 3% of premium for others, with the exact percentage being different for each health plan that pays the fee. We recommend that CMS permit the provision for costs of this type to be outside of the rate range. For example, the additional costs related to the HIPF (the HIPF itself, the effect of income taxes due to the HIPF being treated as a non-deductible excise tax, and premium-based taxes imposed by states) could be as much as 3% of premium. If a state has a health plan that receives no HIPF adjustment and one that receives a 3% adjustment to their premium, including the HIPF in the rate range artificially lowers the allowed range from 5% to 2%. Allowing the HIPF and any other similar health plan-specific costs to be included in the rates outside of the rate range, allows for the intent of the rate range and prevents the need for a separate actuarial certification and CMS approval once the HIPF amounts are known.

- In §438.4(c)(1)(v) CMS proposes to prohibit payment at different points within the rate range due to usage of intergovernmental transfer (IGT) agreements. Yet in the 2016 Final Rule, "To draw down the federal share of an expenditure for a provider payment, including expenditures for supplemental payments, states must document an expenditure that includes a non-federal share. Supplemental payments are typically funded by intergovernmental transfers (IGTs) from local governments, by certified public expenditures (CPEs) from public providers, or by provider taxes, <u>all of which are permissible sources of the nonfederal share of Medicaid spending</u>." (Emphasis added). Would CMS please clarify these items?

<u>Section 42 CFR 438.7(c)(3) +/-1.5%</u>

To what extent does the state actuary need to consider the potential of a state altering the certified rates by +/-1.5%? Should an actuary indicate within the certification whether, absent a corresponding change to the program, that an increase or decrease of 1.5% to the rates would still be considered actuarially sound?

The +/-1.5% creates a 3% range that CMS has described as "de minimis". In the 2016 Final Rule CMS linked the +/-1.5% to just one rate development component – risk margin. Our comments and questions on rate ranges are directly above. However, the inclusion of an underwriting gain (ASOP No. 49; cost of capital + risk margin) is a critical component of Medicaid actuarial soundness and capitation rate development.

Section 42 CFR 438.242 Health information systems (c)(3) Submission of all enrollee encounter data, including allowed and paid amount, that the State is required to report under §438.818

- Please clarify whether, under sub-contracted arrangements, the allowed and paid amounts that the State is required to report to CMS under §438.818 are the amounts allowed/paid by the MCO, PIHP, or PAHP ("MCO") to the sub-contractor, or the amounts allowed/paid by the sub-contractor to the ultimate healthcare provider. For example, if a health plan sub-contracts or sub-capitates with a pharmacy benefit manager (PBM) for pharmacy services, should the allowed and paid amounts represent the amount paid by the health plan to the PBM or the amounts allowed and paid to the retail pharmacy provider?

- Please clarify under sub-contracted arrangements, how the requirement to report allowed and paid amounts will apply to sub-contracted arrangements that do not follow an allowed and paid payment structure. For example, value-based contract payments may not align to a traditional allowed and paid payment structure on a fee for service basis due to risk sharing mechanisms and global service payments. Also, services such as non-emergency medical transportation (NEMT) do not always align with an allowed and paid structure on a per service basis; for example, credits toward bus passes for enrollees with a specific need for multiple trips in a month rather than funding of single trips.

- In Section 12 of the commentary for §438.242 of the 2018 proposed rule (p. 57279), this addition is described as a clarification rather than a new requirement. To the extent this was not previously understood, compliance may require modification of contracts. To avoid retroactive modification of contracts, would CMS consider a future effective date for this section?

- In Section 12 of the commentary for §438.242 of the 2018 proposed rule (p. 57279), CMS acknowledges that in requiring the submission of paid and allowed amounts, it is requiring submission of data that some may consider proprietary, but emphasizes the data is needed to allow for "proper monitoring and administration of the Medicaid program, particularly for capitation rate-setting and review, financial management, and encounter data analysis". It is common for an actuarial certification to begin with a summary of the base period data. In cases where there are few, or even just two participating health plans, such a summary could result in inadvertent potential disclosure of proprietary

data/information. Could you please clarify your expectation of how the receipt and summarized usage of what a health plan has designated proprietary data could affect documentation in the actuarial certification?

Special Payment Provisions 42 CFR 438.6

Section 438.6(b)(1) Risk Sharing Mechanisms

We appreciate the intent of CMS to require that risk sharing mechanisms that affect financial obligations be determined in advance of the contract effective period. From both the health plan and state perspective, it is difficult to manage the insurance risk and the contract when the rules are not defined up front.

Proposed §438.6(b)(1) references "all applicable risk-sharing mechanisms, such as reinsurance, risk corridors, or stop loss limits ..." While the preamble suggests there is a difference between risk adjustment and risk mitigation, we would appreciate further clarification in the rule itself that CMS has made a distinction between risk adjustment and risk mitigation, and that the rules of this section do not apply to risk adjustment. We would also recommend creating definitions for both "risk mitigation" and "risk adjustment" to be placed in §438.2.

Proposed §438.6(b)(1) states that "Risk-sharing mechanisms may not be added or modified after the start of the rating period." We recommend that CMS allow additional latitude with regard to the timing by allowing the risk mitigation strategy to be submitted to CMS at the same time as the initial rate certification even if this is after the start of the rating period, so that the various financial agreements are considered in totality. This is consistent with regulations governing risk adjustment under §438.7(b)(5), which require that all risk adjustment methodologies be submitted with the initial rate certification.

We also recommend that the proposed risk mitigation strategy be open to modifications while CMS is reviewing the rates, so that if CMS does not accept the initially proposed risk mitigation strategy, then the state can modify and propose to CMS an alternative, acceptable strategy.

We recommend that CMS allow more latitude for narrowly focused risk mitigation that may be necessary after the start of the rating period for items that could not have been contemplated during the initial rate setting. This allows for risk mitigation that addresses situations of disproportionate risk that are discovered after the start of the rate period. Examples which illustrate the previously mentioned narrowly focused risk mitigation to allow CMS to consider the potential outcome with each of the example situations:

- Example 1 – After the rates are set, a new life-saving drug is released with an estimated cost of $5 million for a one-time course of treatment. It is estimated that 10 to 20 individuals in the state's managed Medicaid program will be prescribed this drug during the rate period. The state's actuary did not contemplate the cost of this new drug during rate setting. The state wants to carve out these new drugs, because they can't adequately estimate how many members will ultimately be prescribed the

new drug and how much it will cost. They also don't know if the membership will be proportionately shared among all health plans. Under the proposed rule, it is not clear whether the state would be allowed to modify their financial arrangements with the health plans to carve out these specific drugs.

- Example 2 – The state actuaries develop capitation rates assuming a new high cost drug treatment that increases the capitation rates by 2% will come to market in the first month of the rating period. Unexpectedly, the Food and Drug Administration (FDA) delays approval of the drug, and it is unclear in what month or if the drug will be approved during the rating period. The state wants to implement a retroactive risk sharing arrangement on the pharmacy costs in the capitation rates to ensure that the health plans are not overpaid due to the delay in the drug approval. Using the risk sharing arrangement allows an automatic adjustment to the rates, no matter when the drug is approved, without the burden of waiting for approval, developing new rates with the new assumption on the drug usage, and developing and submitting a new actuarial certification for CMS approval as would be required under the proposed rule.
- Example 3 – After the rates are developed, the state discovers a sub-set of 20 to 50 enrollees who meet eligibility requirements under the Temporary Assistance for Needy Families (TANF) program, but have cystic fibrosis and require significant home health services. While a diagnosis-based risk adjustment is applied to the premiums paid to the health plans, it does not adequately differentiate between the levels of home health services needed by these enrollees. Due to the low number of individuals and the low capitation eligibility cohort, health plans have disproportionate shares of these individuals. The state wants to establish a risk pool for these individuals that would withhold a portion of capitation from all health plans and then redistribute the capitation withhold, in a budget neutral manner, according to their portion of claims for these individuals.

<u>Section 438.6(c) State Directed Payments</u>

We appreciate CMS's review of state-directed payments in managed care and its willingness to add some flexibility for these payment arrangements. We do, however, have a few questions for clarification:

- State plan versus supplemental payments (Sections 438.6(a) and (c)(1)(iii)(A)): We request clarification on the difference between a state plan-approved rate and a supplemental payment. In some states, there are situations where there is a per unit price set at an amount higher than the Medicaid fee schedule for a class of providers, and this higher price has been approved in the State plan. The difference between the higher rate and the Medicaid fee schedule amount is funded by IGTs and/or paid retrospectively, but the total payment is still based on the number of units incurred for the applicable services. Is this considered a state plan approved rate or a supplemental payment?

- Process for approval (§438.6(c)(2)): We request clarification on the requirement of written approval for state-directed payments under proposed §438.6(c)(1)(iii)(A). The proposed regulation states that these arrangements "do not require written approval prior to implementation". Do these arrangements require written approval concurrent with the capitation rate certification or not at all?

- Approval timeframes (§438.6(c)(3)): We request clarification of the reference to paragraph (c)(1)(iii) in proposed §438.6(c)(3)(ii). Are state-directed payments under §438.6(c)(1)(iii)(A) subject to approval for one rating period, or are they excluded from this limitation because they are already approved under the state plan rate methodology? Would CMS be open to additional directed payment types being available for multi-year approvals? We believe this would be a positive step in increasing program stability.

Section 438.6(d)(6) Pass-through Payments for States Transitioning from FFS

The proposed language in Sections 438.6(d)(6)(iii)(A) – (C) seem to limit the evaluation of allowable pass-through payments at the broad provider type level of hospital, nursing facility and physician. Is it permissible to perform the calculation at the provider class level, if the pass-through payments are not applicable to all services within the broad provider type?

Other

Section 438.8 Medical Loss Ratio (MLR)

The only changes to the MLR standards section are for fraud prevention language in Sections 438.8(e)(4) and 438.8(k)(1)(iii). We support this change which results in alignment across commercial, Medicare, and Medicaid/CHIP business MLR calculations.

Though not raised in the proposed rule, historically, for §438.8(e)(2)(i)(A) CMS has said that all services, including behavioral health, acute care, pharmacy, NEMT, and LTSS are included in the definition of direct claims for purposes of the MLR numerator. We request that CMS add state-approved value-added services to the services that are included in the numerator of the MLR calculations. Value-added benefits are typically included to support improved health care quality and outcomes, and can make a visible and notable dent in addressing social determinants of health and foster innovation and sharing best practices in the managed care industry for the most vulnerable populations. To accomplish this CMS could:

- Add a bullet under the 'Incurred Claims' sub-header that says, "Value Added Benefits provided by the MCO and approved by the state".

- Change the bullet under the sub-header 'Exclusions from Claims' to say "Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for state plan services, or services meeting the definition in §438.3(e) and provided to an enrollee, except for Value Added Benefits as defined in the Incurred Claims sub-header above".

States may, but are not required, to include rebating of premium as a feature of the MLR reporting process. We recommend that CMS expressly say that a state's MLR-based premium rebate calculation may include elements that are different from the CMS MLR reporting requirements. For example, the contract between a state and an MCO could require that the MCO purchase individual stop loss reinsurance for claims larger than a specified amount that is based on the number of members covered by the MCO. The state's MLR premium rebating calculation could include the net cost of reinsurance (reinsurance premiums less reinsurance recoveries) in the numerator. This would be different from the CMS MLR calculation, which uses direct claims (not claims net of reinsurance) in the numerator.

Medicaid managed care actuarial soundness pre 2016 Final Rule

Actuarially sound capitation rates and/or rate range requirements for Medicaid managed care date back to the 1997 Balanced Budget Act and prior. With due respect to the credentialed actuaries who certified them, the excellent state staff who submitted them to CMS, and the dedicated CMS Regional and Central Office staff who approved those rates and/or rate ranges, we believe the statement, in the November 14, 2018 Federal Register, page 57267, "Additionally, we believe the rate ranges compliant with our proposal will be actuarially sound, unlike the rate ranges that were permissible prior to the 2016 final rule.", to be inaccurate.

Next Generation

Social Determinants of Health (SDOH):

We recognize an increasing willingness (HHS Secretary Alex Azar comments[4] regarding the Center for Medicare & Medicaid Innovation's (CMMI) efforts on SDOH, MassHealth's Flexible Services Program scheduled to begin January 2020, North Carolina's recently approved waiver also provides a federal match for services that will affect determinants of health, etc.) on the part of CMS to identify ways to financially support states that are developing programs to address the social determinants of health. Medicaid health plans have built community partnerships and developed value-added benefits (addressing food insecurity and physical activity, stable housing, etc.) to meet the social needs of beneficiaries.

We recommend that CMS formally examine either through an established working group or through a government-supported research body (e.g., Medicaid and CHIP Payment and Access Commission (MACPAC) or the Government Accountability Office (GAO)) how plan investments focused on affecting social determinants of health might be included in Medicaid capitation rates. We recognize the legal and administrative challenges associated with including SDOH-related investments in the capitation rates. However, evidence suggests that the value and return on investment (ROI) directly correlated to SDOH investments benefits states, Medicaid programs, and Medicaid populations, thus we believe policy permitting

[4] https://www.aha.org/news/headline/2018-11-14-azar-previews-hhs-plans-address-social-determinants-health

Medicaid payment for these activities and services could have significant implications for population health and cost savings.

After a thorough vetting of implications, some initial recommendations potentially could be:

- Allow appropriate costs related to SDOH to be included in the numerator of the MLR calculation. This would encourage more spending on evidence-based items that would help the overall health of the beneficiaries.
- Provide flexibility for states to include in capitation rate setting all or a portion of the cost of services avoided as a result of investments in SDOH, based upon CMS-developed guidance to states.
- It would also be helpful if CMS could facilitate the collection of data related to SDOH and support research regarding how they can be incorporated into risk adjustment mechanisms. This will help states pay health plans more appropriately for populations with variations in social determinants impacting health care costs.

Payment by the State for Value or Outcomes Instead of Volume:

CMS should address expanding flexibility within capitation rate-setting for a state to pay high quality, cost efficient, and effective health plans for value or outcomes, instead of volume. There is considerable guidance on how health plans can work with direct providers of care to reimburse for quality/value; however, there is not much flexibility on how states can pay health plans for outcomes. If health plans provide quality/value that leads to healthy members and low claim and encounter volume, the health plans may be penalized through lower rates in future years and paybacks of revenue through risk sharing arrangements, although they are achieving the state's purpose of improving health.

Section 42 CFR 438.6(b)(3) Withhold Arrangements

§438.6(b)(3) states that "Contracts that provide for a withhold arrangement must ensure that the capitation payment minus any portion of the withhold that is not reasonably achievable is actuarially sound as determined by an actuary." We believe there is limited line of sight for the state actuary to determine what portion of the withhold should be considered reasonably achievable due to the contract negotiation typically being separate from the capitation rate development. We suggest CMS to include in the annual rate development guidelines a general process for the actuary to follow in making this determination, such as:

- Review the language and criteria for earning back the withhold for prior contract years.
- Review the language and criteria for earning back the withhold for the rate period.
- Assess the differences between prior years and the rate period.
- Review the achieved earn back by the health plans in prior years.
- Based on the above, extrapolate and use actuarial judgment to determine the achievable amount.

Alternative cost effective approaches such as health plan attestation related to the appropriateness of the withhold amount may be considered.

Section 438.6(b)(3) requires that "The total amount of a withhold, achievable or not, must be reasonable and take into consideration the health plan's financial operating needs accounting for the size and characteristics of the populations and the health plan's capital reserves or months of claims reserve." This requirement is too restrictive in that the certifying actuary is not ensuring solvency or opining on the appropriateness of the capitation rate for any single health plan. This requirement puts unintended and inappropriate responsibility on a state-employed actuary related to the financial condition of a health plan with which they are not related and responsible. We request that this portion of the requirement be removed to clarify the intended responsibility of the certifying actuary.

Key Points Summary

- The Academy's Medicaid Subcommittee supports necessary capitation rate development transparency and documentation requirements. As requested by CMS, several comments and questions regarding specific aspects of CMS-2408-P are included in this letter.
- While progress has been made, timing of implementation and particularly the cost and burden to states and their staff of the 2016 Final Rule, and this CMS-2408-P, remain of significant concern.
- The subcommittee stands ready, and offers any assistance desired by CMS, in working through details associated with and of our comments or questions.

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The subcommittee welcomes the opportunity to speak with you about any of the items discussed in this letter, and offers assistance on any desired topic. If you have any questions or comments, please contact David Linn, the Academy's senior health policy analyst (202-223-8196, linn@actuary.org).

Sincerely,

Michael E. Nordstrom, MAAA, ASA
Chairperson, Medicaid Subcommittee
American Academy of Actuaries