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# Improving Rate Setting and Risk Mitigation in Medicaid Managed Care

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# Agenda

- Background
  - Prior work on rate setting
  - Anticipated rulemaking on managed care
- Policy issues related to managed care rate setting
  - Areas likely to be raised in future rulemaking
  - Areas potentially excluded from rulemaking where the Commission could offer comments
  - Option that requires federal statutory change
  - Area with little or mixed evidence to support a policy change
- Next steps

# Background

# Prior Work on Rate Setting

- MACPAC conducted several studies last year that provided an in-depth examination of federal managed care rate setting and risk mitigation tools
  - Expert roundtable on risk mitigation
  - Study on the rate development process and actuarial soundness requirements
  - Research and recommendations on managed care directed payments
- Findings presented in the spring suggested several potential policy areas for consideration
- Staff conducted additional interviews (CMS, plans, state actuaries) to gather more data on these issues

# Anticipated Rulemaking on Managed Care

- U.S. Department of Health and Human Services (HHS) announced this summer its intent to purse rulemaking on several issues that affect managed care rate setting
  - one rule focusing on access
  - another rule addressing ILOS, directed payments, and other managed care topics
- Rules are expected to be released in late 2022 and early 2023
- Several of the policy areas where staff conducted additional research are likely to be addressed
- These rules provide the Commission with an opportunity to comment on federal managed care rate setting policy

# Policy Areas Likely to be Raised in Future Rulemaking

# ILOS and Value-Added Benefits in Rates

- Growing state interest in pursuing non-traditional services for Medicaid beneficiaries to address social determinants of health (SDOH)
- Stakeholders indicate that more guidance is needed
  - Distinguishing in-lieu-of services (ILOS) from value-added benefits
  - Capturing ILOS costs in capitation rates
  - Clarifying treatment of SDOH-related services, such as ILOS, in MLR calculations
- Many stakeholders believe additional guidance could better align rate setting process with state goals and streamline review process

# Approval Process for Directed Payments

- Follow-up research reinforced the Commission's previous findings related to directed payments
  - Actuaries have limited to no role reviewing directed payments
  - Link to quality and access goals is unclear
- Directed payments can complicate rate review and approval
  - Some payments require actuaries to back into per member per month amounts using expected utilization
  - Retroactive reconciliations can be considered a rate change that requires CMS approval
- Commission recommendations in June report to Congress did not address these areas

# Accounting for Access in Rate Setting

- No explicit approach for addressing access in rate setting
  - No federal guidance
  - No professional actuarial guidance
- Actuaries and health plans have limited tools to assess access in rates
  - Typically assume FFS fee schedules and historical rates are appropriate to ensure access for beneficiaries
  - Plans have limited information on state rate-setting assumptions
  - Managed care access measures are more structural in nature (e.g., time and distance requirements)

# Policy Areas Potentially Excluded from Rulemaking Where Commission Could Offer Comments

# Expedited Rate Reviews and Midyear Changes

- MACPAC research suggests CMS could take further steps to streamline the rate review process
  - Expedited rate reviews (e.g., Appendix K authority for 1915(c) waivers)
  - Potential limitation to emergency situations
  - Clarity on documentation requirements for rate amendments
- Stakeholder feedback varied on the need for expedited review authority
  - Accelerated review exists for select rate submissions
  - Careful review of program changes is important
  - Helpful tool to address future system shocks

# Retroactive Changes to Risk Mitigation Tools

- Risk mitigation tools must be defined in contracts at the beginning of the rating period
  - Retroactive changes during the pandemic was unique circumstance
  - No plans to allow retroactive changes in future
- States found this to be a helpful tool
  - Could provide protection against future system shocks
- Health plans view retroactive changes as disruptive
  - Complicate operational decisions
  - States have other tools at their disposal
- Potential flexibility could be limited to specific circumstances

# Transparency in Rate Setting

- Transparency in current rate setting process is limited
  - No federal requirements for health plans to review assumptions
  - State variation in what is shared
- Stakeholders indicate transparency could potentially improve rate setting process
  - Provides a roadmap of what has been approved in other states
  - Reduces back-and-forth with CMS during rate reviews
  - Plans can better meet state goals

# Policy Option that Requires Federal Statutory Change

# Partial Deferral Authority for CMS

- Current CMS oversight authority is limited
  - Agency can ask questions and clarify assumptions but can only approve or disapprove the entire rate certification
  - Can approve or reject specific payment methodology changes in FFS
- Partial deferrals raised as a potential tool in 2016 proposed managed care rule and 2022 president's budget
- Stakeholder feedback was mixed
  - Concerns regarding the scope of authority; need for precise parameters
  - More feasible for separate payment terms or portions of administrative costs
- Many stakeholders see this as a seldom used but helpful tool in rate reviews

# Policy Area with Little or Mixed Evidence to Support a Policy Change

# Multiyear Risk Mitigation Mechanisms

- Policy issue raised during expert roundtable discussion
  - Could help increase budget predictability and reduce administrative complexity
  - Helpful when taking on new populations or services
- Current rules permit multiyear arrangements
  - Defined in contract at the beginning of rating period
  - Rarely used by states
- Little support among stakeholders for this flexibility
  - Cashflow and reporting challenges
  - Alignment with the rate year

# Next Steps

# Next Steps

- Commissioner discussion on policy issues likely to appear in rulemaking
  - Review discussion questions; identify other questions of interest
- Commissioner feedback on other policy areas
  - Identify other areas of interest that could inform future comments
- Commission feedback on other items
  - Assess commissioners' interest in pursuing future work on partial deferrals
  - Confirm whether multiyear risk corridors should be dropped from further consideration

# Summary of Policy Areas Discussed

| Category | Policy Areas |
|---|---|
| Areas likely to be raised in future rulemaking | • ILOS and value-added benefits in rates<br>• Approval process for directed payments<br>• Accounting for access in rate setting |
| Areas potentially excluded from rulemaking where Commission could offer comments | • Expedited rate reviews and midyear changes<br>• Retroactive changes to risk mitigation tools<br>• Transparency in rate setting |
| Option that requires federal statutory change | • Partial deferral authority |
| Area with little or mixed evidence to support a policy change | • Multiyear risk mitigation mechanisms |

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