Comment #5 – 4/29/14 – 1:16 p.m.

April 29, 2014

TO: ACTUARIAL STANDARDS BOARD

FROM: JOHN DUTEMPLE, FSA, MAAA

SUBJECT: PROPOSED ACTUARIAL STANDARD OF PRACTICE

Thank you for this opportunity to comment on the exposure draft of the Medicaid Managed-Care Capitation Rate Development and Certification ASOP proposal. My thanks also to the professionals involved in bringing this much-needed guidance to this stage.

I will first answer the direct questions posed by your request for comments and then make some additional suggestions for the ASB's consideration. In the interest of full disclosure, please be aware that I am currently employed by an MCO, though I strive to be unbiased in my comments. These comments represent my opinions only, not those of my employer.

1. This ASOP should apply to actuaries developing both rate certifications under 42 CFR 438.6(c) and actuarial statements of opinion for MCOs. Many actuaries work for both parties at different times and should be held to the same standard regardless of principal. Furthermore, the realization and disclosure of the reality of negative underwriting gain for internal business reasons gives the MCO actuary a good deal of latitude.
2. Not only should the ASOP apply to CHIP as written, it should be clarified that it applies to non-TANF/CHIP populations such as ABD and the Medicaid-covered benefits of dual (Medicare/Medicaid) eligible members including Integrated Duals programs.
3. The definition of actuarially sound/actuarial soundness is clear.
4. The actions described in section 3.2.16 are clear and appropriate, but do not go far enough. As the Medicaid program is clearly one of public rather than private interest, and further, to support Precept 8 of the SOA Code of Professional Conduct, where work has been performed in development of rate certifications under 42 CFR 438.6(c) for State Medicaid Agencies, the actuary should notify the affected MCOs as well as their principal.
5. The proposed ASOP does not restrict practice inappropriately.
6. The proposed ASOP does provide sufficient guidance to actuaries practicing in these areas.
7. With the change suggested in (4.) above and the following suggested change in the wording of section 3.4, this proposed ASOP goes a long way towards addressing potential inconsistencies in the expectations of the actuaries working for their respective principals. Section 3.4 should be amended to read:

   "3.4 <u>Documentation</u> – The actuary should document and, in the case of rates developed for rate certifications under 42 CFR 438.6(c), disclose to the MCOs the methods, assumptions . . ."

> The State Medicaid Agencies will always have an informational advantage inasmuch as they will have data from all MCOs and often offer rates on a take-it-or-leave-it basis after much investment by the MCOs in a state. In the interest of transparency, assessment of reasonableness and in support of Precept 8 of the SOA Code of Professional Conduct, this documentation should be shared.

I also offer the following changes to add clarity to the proposed ASOP:

Section 3.2.2 should be clarified to address delivery, low birth-weight, and/or transplant supplemental payments (a.k.a. ‘kick’ payments), which qualify not by eligibility class or diagnosis alone, but require a specific procedure or set of procedures.

Section 3.2.2 should also address cases where individual rates cells are not actuarially sound, but taken in aggregate would be. For example, state-wide capitation amounts where individual regions would not be credible. Also, in some states NICU kick payments are designed to only cover a percentage of NICU costs with the rest left in capitated rate cells to provide an incentive for pre-natal care and reduce the need for NICU.

Section 3.2.3 should be clarified to address the practice of using interim financial results to update rates without a formal rebasing. As an example, one state used CY09-10 data to set FY13 rates, updated those rates with trend and plan changes (not rebasing) to FY14, then reduced those rates based on FY11 experience; a de facto rebasing to FY11 financial information disguised as an update.

Section 3.2.4 should expand its focus to included membership base data sources as PMPM capitation can be distorted by inaccurate membership data as well. The current wording is very claims focused. At least one state has had issues enrolling newborns multiple times and not correcting the error (or the capitation rates) until years after the fact.

Section 3.2.9 should be clarified that the actuary must consider the aggregate impact of managed care and not apply adjustments in isolation (e.g. reduction in ER utilization may be accompanied by higher primary care utilization, possibly with higher per unit costs in both settings, as delivery of care is managed towards the appropriate setting.)

Section 3.2.13 should be expanded to address the presence (if any) of retrospective payments made outside the base period that appropriately should be accounted for in the base period.

Respectfully Submitted,

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