Minnesota Department of **Human Services**

May 9, 2014

Exposure Draft Comments
Actuarial Standards Board
1850 M Street, NW
Suite 300
Washington, DC 20036

RE: Comments on Exposure Draft – Medicaid Managed-Care Capitation Rate Development and Certification

To Whom It May Concern:

Thank you for the opportunity to comment on the "Medicaid Managed Care Capitation Rate Development and Certification" exposure draft. The Minnesota Department of Human Services, Minnesota's Medicaid Agency, supports the goal of providing additional guidance for Medicaid program actuaries. Our comments on the new actuarial standard of practice follow:

Section 2.1 Actuarially Sound/Actuarial Soundness
We support a proposed revision submitted by commenter Daniel Bailey on February 4, 2014, which provides:

> Medicaid capitation rates are developed prospectively for a specific future period, population, benefit, and geographic area. These projected Medicaid capitation rates are "actuarially sound" if they provide for all reasonable, appropriate, and attainable costs, in combination with all other revenue sources…

However, we suggest deleting the word "attainable" which might be construed as a requirement to achieve a certain level of costs. Instead, we propose substituting the word "well-managed" as an adjective to describe costs. Our suggested definition is as follows:

> 2.1 Actuarially Sound/Actuarial Soundness - Medicaid capitation rates are developed prospectively for a specific future period, population, benefit, and geographic area. These projected Medicaid capitation rates are "actuarially sound" if they provide for all reasonable, appropriate, and well-managed costs, in combination with all other revenue sources. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, health benefits; health benefit settlement expenses; administrative expenses; government-mandated assessments, fees, and taxes; and the cost of capital.

Competitive Procurement

We suggest inserting a definition for the term "competitive procurement." Capitation rates have traditionally been established by the state setting rates or through a competitive bidding process within which competitive bids are required to fall within an actuarially sound range. However, state Medicaid agencies may also conduct a competitive procurement that is a hybrid between state-set rates and lowest-cost competitive bidding. "Best value" purchasing is a process through which MCOs bid or otherwise make offers for capitation rates for certain geographic areas based on price and quality with the understanding that the state may limit the number of MCOs providing service in those geographic. We suggest the following definition:

> Competitive Procurement—A process in which a state Medicaid agency enters into a managed care contract pursuant to a full and open competition in which competitive bids are offered in response to requests for proposals and evaluated by the state based upon criteria (e.g., low cost and quality) to achieve best value through selective contracting.

Covered Services

We suggest inserting a definition of "covered services." The phrase is not defined despite being used throughout the draft. Section 3.2.5 uses the terms "covered services" and "state plan services" as synonyms, which is not entirely correct. Medicaid beneficiaries covered through managed care contracts may receive state plan services, services provided as substitutes for state plan services, and waivered services. We suggest the following definition:

> Covered Services—Items or services covered under Title XIX by virtue of the Medicaid state plan or waiver authority, and covered under the contract with the MCO.

Section 2.6 Enhanced or Additional Benefits

We recommend that the phrase "state Medicaid plan" should be replaced with the newly defined phrase "covered services" found in Section 2 Definitions.

Section 2.17 State Plan Services

In combination with the addition of a definition of "covered services" as described above, we recommend deleting the definition of "state plan services" at section 2.17 because it is incorrectly used to define the Medicaid benefit.

Section 3.1 Overview

We support the concept that a soundness opinion applies to all capitation rates and that an actuary is not certifying the assumptions are appropriate for an individual MCO. We also note that an MCO may be required to take action (e.g., better manage utilization) to meet the underlying assumptions in the rates.

3.2.3 Rebasing and Updating of Rates

Minnesota views a competitive procurement, which requires MCOs to submit capitation rates as bids, to be a form of rebasing. A competitive procurement that limits the number of MCOs serving a geographic area or population requires MCOs to bid a capitation rate using their best, most competitive assumptions. We believe it would be appropriate for the actuary to consider competitive bids as a means to update rates and therefore recommend competitive procurements and bidding be addressed in this section.

3.2.4 Base Data

We recommend adding the following language to the first paragraph under Section 3.2.4:

> The actuary should use base data (for example, population, benefits, provider market dynamics, geography) that is appropriate for the program for which capitation rates are being developed. The base data may span more than one year. In general, utilization and cost data should be compared to external sources by the actuary to develop appropriate trends and to identify areas of focus. Comparison to external sources such as national or commercial data, instead of relying only on local data, will assist in managing trends to a more appropriate level over time and will not reward poor management with higher rates.

3.2.5 Covered Services

The first sentence of this Section is difficult to read, particularly after the addition of the phrase "covered services". Consequently, we recommend modifying the first sentence to say, "To determine which items and services should be included in the capitation rate, the actuary should include covered services that form the basis for the claims experience used to develop the rates."

The last sentence of this paragraph provides that enhanced or additional services should not be included in the rate development and should be excluded from the data used to develop the capitation rates, unless provided for by a waiver. By defining "covered services" to include services covered by Medicaid and the contract by virtue of waiver authority, and using "covered services" throughout the document, there would be no need to refer to waiver services in this sentence. We also note that the phrase "enhanced or additional services" should be the phrase "enhanced or additional benefits" to match the definitions. Making these changes Section 3.2.5 would read:

> Covered Services - To determine which items and services should be included in the capitation rate, the actuary should include covered services that form the basis for the claims experience used to develop the rates. The actuary should identify any material historical or anticipated changes to covered services so that appropriate adjustments can be made to the claims experience. The actuary should also identify any special payments to providers (for example, supplemental payments or bonuses) and ensure that these payments are handled consistently between the base data and the capitation rates. Non-covered services may be included in the capitation rate if the service is provided in lieu of

a covered service. If a certification is prepared under 42 CFR 438.6(c), enhanced or additional benefits should not be included in the rate development and should be excluded from the data used to develop the capitation rates.

3.2.7 Other Base Data Adjustments

We recommend adding two additional paragraphs to this section as follows:

h. Area Factor Adjustments - Geographic variation in costs within a state may be considered if there has historically been a consistent differential in costs over time. The underlying cost data to develop the rates must support the different cost factors used. Geographic areas (e.g., counties) with similar cost levels should be grouped together. The variation should also be supported in the base data.

i. Affiliated Provider Organizations - MCO payments to affiliated provider organizations, including subsidiaries and other organizations under common control with the MCO may be in the base cost data. These services should be valued at cost. If cost exceeds the amount that unaffiliated providers would be paid for the same services, the actuary should evaluate whether the full cost is appropriate to include in the base data and make any necessary base data adjustments to account for the affiliated relationship. Base data may exclude costs exceeding what the MCO would pay to an unaffiliated provider.

3.2.11 Non-Medical Expenses

We support a comment submitted by Michael Cook on April 10, 2014 which provides:

Section 3.2.2 and 3.2.11.a.i – These sections imply that separate administrative loads should be developed for each rate cell. However, this conflicts with current practice in most programs I am aware of. This would likely require the establishment of fixed and variable loads for every rate cell. This could also impact risk adjustment calculations, with the variable portion of administration revenue being adjusted and the fixed portion not being adjusted. I would propose retaining the current guidance as issues to be considered, while adding language that allows the certifying actuary the flexibility to determine whether there are material variances in the rate cell mix of enrollees, either across MCOs or relative to expected for a particular MCO, that result in an inappropriate distribution of administrative revenue in the contract period for a particular MCO. If such variances are not present, it would not be required to develop separate fixed and variable administrative cost loads.

In Section 3.2.11.1, Determining of Administrative Expenses, we recommend adding a note to this section that addresses administrative expenses paid to affiliated organizations or subsidiaries. We recommend adding the following language:

MCO administrative payments to affiliated organizations, including subsidiaries and other organizations under common control with the MCO, may be in the administrative

> cost data. These administrative services should be valued at cost. If cost exceeds the usual market value of the same services, the actuary should evaluate whether the full cost is appropriate to include in the administrative cost data and make and necessary data adjustments to account for the affiliated relationship. Administrative cost data may exclude costs exceeding what the MCO would otherwise pay in the market.

In Section 3.2.11.a.2.i, it is not clear what is meant by the phrase "competitive environment," nor is it clear how this should be accounted for with administrative expenses. We recommend deleting the phrase.

In Section 3.2.11.a.2.iv, it is critical to note that only "appropriate" general corporate overhead should be accounted for in rate development. States must have the ability to reasonably limit corporate overhead. For example, Minnesota law (i.e., Minnesota Statutes § 256B.69, Subdivision 5i) prohibits including the following overhead costs in rate development:

- Charitable contributions made by an MCO;
- Any portion of an individual's compensation in excess of $200,000 paid by an MCO;
- Any penalties or fines assessed against an MCO; and
- Any indirect marketing or advertising expenses of an MCO.

In Section 3.2.11.b, Underwriting Gain, we support the position that the "actuary may reflect investment income in establishing the underwriting gain component of the capitation rate, although an explicit adjustment is not required." However, we suggest that the phrase "may reflect" should be replaced by the phrase "must consider" to emphasize this evaluation.

Also in Section 3.2.11.b (second paragraph), we recommend addressing the importance of allowing an MCO to submit a bid with a negative underwriting gain as part of a competitive procurement. A MCO responding to a competitive procurement may want to bid with a negative underwriting gain as part of a business growth strategy to gain market share or to garner adequate enrollment as part of entering a new market.

3.2.12 Risk Adjustment

We recommend that ASOP No. 45 (The Use of Health Status Based Risk Adjustment Methodologies) also be updated.

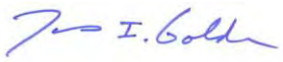
3.2.14 Performance Withholds/Incentive

We support a comment submitted previously by Michael Cook on April 10, 2014 which provides:

> I agree with the statement that capitation rates should reflect "the value of the portion of the withholds for targets that the MCOs can reasonably achieve." However, this conflicts with consistent CMS requirement that rates be certified as actuarially sound assuming that none of the withhold is returned. While not necessarily something to be addressed

within the ASOP, we should encourage education within our community about this issue and the requirement to adhere to Section 4.2.d (the second "d") if this difference in assumptions is material.

Sincerely,



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