Comment #20 – 5/15/14 – 5:12 p.m.

Thank you for the opportunity to comment on the exposure draft for the **Medicaid Managed-Care Capitation Rate Development and Certification ASOP**. These comments reflect my own thoughts on the material and do not represent either my firm or my clients.

Responses to the questions posed by the task force:

1. Yes, I believe the ASOP should apply to both state and MCO actuaries. As noted in the comments below, I think some of the requirements need to be clarified in terms of how they apply in different situations.

2. Yes, the provisions should apply to CHIP as well.

3. No, please see comments below that request clarification to the definition.

4. Yes, the requirement is clear but it may be unnecessary.

5. Please see comments below.

6. Please see comments below.

7. Please see comments below.

2.1 Actuarially Sound/Actuarial Soundness

The definition for actuarial soundness states that the assumptions around costs must be "attainable". This term lacks clarity and creates an opportunity for dispute between health plans and states, and their respective actuaries and lawyers.

Consider the following real example. In a local market within a given state, providers historically demanded payment well in excess of the state's fee schedule to participate in the Medicaid managed care program. The state decided that the program was not cost effective and lowered prospective capitation rates while instructing the MCO to reduce unit costs. The providers refused and the MCO was forced to pull out of the service area. At first blush this appears that the state's actuary would have violated the attainability clause of setting actuarially sound rates. However, two additional points should be considered. First, it does not seem reasonable to expect the state to pay costs in excess of fee-for-service or market norms just because a local group of providers demand it. The outcome of not offering managed care in that locality seems like a reasonable position. Second, in this particular situation, the providers accepted the lower rates a couple years later, and the local area is once again in managed care but now at lower unit costs.

Defining actuarial soundness by using near-term attainable assumptions does not address the need some states may have to limit unit costs within a managed care program.

2.1 Actuarially Sound/Actuarial Soundness

The definition of actuarial soundness indicates that expected commercial reinsurance cash flows should be considered. This is particularly problematic from a state actuary's perspective when the state sets a single set of rates for all participating MCOs. Suppose half of the participating MCOs are large multi-state organizations that purchase no reinsurance coverage and the other half are smaller local plans with significant commercial reinsurance coverage. This language would seem to necessitate rates that are tiered by MCO. Taken a step further, this language would begin to imply that economies of scale for larger organizations should be considered, which would eliminate the State's ability to establish standardized rates for all MCOs.

3.2.2 Structure of the Medicaid Managed-Care Capitation Rates

The language in section 3.2.2 seems to present a vision for rates that are unique to each MCO by including "MCO differences" in the list of characteristics. This emphasis on MCO specific characteristics in the rates setting seems inappropriate. It implies that firms with less efficient administration, less effective provider contracting or weaker care management efforts should be compensated in the rate setting process. This also seems inconsistent with section 3.1, which states that "the actuary is not certifying that the underlying assumptions supporting the certification are appropriate for an individual MCO."

3.2.8 Claim Cost Trends

Section 3.2.8 states that claim cost trends should be exclusive of other adjustments. My interpretation is that this would prohibit a blending of the utilization component of trend with the adjustment in 3.2.9, managed-care adjustments. However, if years of managed care data are being used to develop those trends, it seems like an unnecessary exercise to separate historical utilization trend and managed care savings components.

3.2.9 Managed-Care Adjustments

Section 3.2.9(b) says that the actuary should consider the "current characteristics of the provider markets". I suggest that the actuary should also consider desired changes in those characteristics.

3.2.11 Non-Medical Expenses

Section 3.2.11(a)(1)(i) further makes the point of MCO specific rating, which is not consistent with current practices in many states. If we wish to make this a requirement, we need to clarify expectations about defining an MCO and the level of reliance to be placed on MCO specific accounting practices. For example, does a state actuary setting Medicaid capitation rates now need to understand how a state specific MCO subsidiary of a national company does their

corporate overhead allocations or are we suggesting that the state's actuary must just accept the practices of the MCO and their parent company? This point seems to apply only to the actuary working for a single MCO.

Section 3.2.11(c) would indicate that the state should differentiate rates between for-profit and non-profit MCOs. This does not seem politically feasible.

3.2.14 Performance Withholds/Incentives

Section 3.2.14 suggests that the actuary consider the achievability of withholds. This seems inconsistent with the expectations of CMS in the rate certification process. Furthermore, the achievability of those withholds may vary across MCOs. The language is not clear as to whether an actuary setting rates on behalf of a state must consider the average level of achievability across all MCOs or the lowest level of achievability for the MCOs.

Respectfully,

Justin Birrell