Comment #23 – 5/15/14 – 6:38 p.m.

I would like to thank the committee that developed the proposed Actuarial Standard of Practice (ASOP), Medicaid Managed-Care Capitation Rate Development and Certification, for its hard work and excellent Exposure Draft (Draft). I thank the Actuarial Standards Board for the opportunity to comment and respectfully submit the following questions and comments related to this ASOP. Please note that these comments are mine alone. They reflect my past experience working both on State developed Medicaid rates/rate ranges and on MCO Medicaid bids, as well as my understanding of current Medicaid rate setting practices and what I believe to be appropriate actuarial practice. They do not reflect any particular situation or engagement, nor do they necessarily reflect the views of my current or past employers.

2.1 Actuarially Sound/Actuarial Soundness: As stated below, I believe this definition is clear and appropriate. However, it would be helpful to clearly state in the ASOP that the assumptions built into the selected rates must be attainable, throughout the State, for each covered population, on average during the contract period. Do rates need to be attainable by only one contracting entity or for all entities needed to ensure appropriate beneficiary choice? In addition, the ASOP could be explicit regarding the fact that soundness in the rating period does not consider past gains and losses.

2.3 Capitation Rates: The final sentence of this definition includes reference to capitation rate structures that share risk with the State or other MCOs. In Minnesota, the State requires MCO participation in a program that shares risk between the State, the MCOs and certain participating provider systems. Should the phrase, "or with providers" be added at the end of the final sentence to cover these types of arrangements?

2.6 Enhanced or Additional Benefits, 2.17 State Plan Services, and 3.2.5 Covered Services: The concept of State Plan/Non-State Plan services, additional benefits, and in lieu of benefits, seems to be the one of the most difficult concepts to understand. My suggestions include:

1. Add a definition of services provided in lieu of State Plan services or substituted for State Plan services. My understanding is that to be considered in the capitation rates, these services must be cost effective alternatives to State Plan services. The current draft doesn't clearly state this.
2. Tie the definition of State Plan services, to the Medicaid State Plan as approved by CMS. Also, make it clear that State Plan services would not cover all benefits provided by the MCOs to the Medicaid beneficiaries if MCOs choose to cover " Enhanced or Additional Benefits".

3.2.1 Form of the Capitation Rates: I suggest the following clarifications be made in the ASOP or in practice guidance if the committee agrees with these assertions:

- Clarify that maternity delivery payments and other types of kick payments are covered by the ASOP;
- In certifying a rate range, the actuary is certifying that every point in the rate range meets the definition of Actuarial Soundness for all geographic areas and populations

covered by the range. Multiple ranges may be needed if the assumptions used at the top or bottom of the range are not attainable in all geographic areas of for all population groups;

- The combination of assumptions used must be attainable at all points in the rate range on average during the contract period. In other words, the combination of all best case assumptions or all worst case assumptions may not be reasonable in aggregate; and
- Rates at the low end of the range may include more administrative expenses than rates at the top of the range to account for increased medical management.

3.2.5 Covered Services: The current section notes that special payments to providers should be handled consistently in the base data and the capitation rates. It seems that there may be situations where a difference would be warranted due to a change in practice between the base period and rating period.

3.2.7a. Other Base Data Adjustments: I'd suggest that this section address differences between encounter data and MCO reported financial data. These differences may be due to errors in processing encounter data that should be investigated prior to using encounter data that may be missing valid claims.

3.2.9 Managed Care Adjustments: I support the language requiring managed care adjustments to be attainable in the rating period. I would also ask the committee to consider requiring actuaries to document the basis of managed care assumptions. These assumptions may be easily justified for a relatively new program with capitation rates based on fee for service data. However, the actuary should provide the basis for reductions made to MCO costs for established programs, including indicating specific benefit areas where the actuary believes MCOs' current care management practices or provider contracts are deficient and the potential savings in these areas. I'd suggest the list of considerations also include time required to re-contract with providers.

3.2.11.b. Underwriting Gain: In my experience, this is another area where confusion seems to exist. I would welcome additional clarification in the ASOP or practice guidance. It would be helpful to include considerations, possible methodology or guidance for determining appropriate cost of capital when certifying rates under 42 CFR 438.6(c). How is an "appropriate" underwriting gain provision determined? I agree that negative underwriting gain may be appropriate for a given MCO's circumstances and should be allowed in MCO bids. However, I suggest the negative underwriting gain should be disclosed in the actuary's documentation and certification. In addition, I suggest the actuary be required to understand the MCOs plan for returning the Medicaid line of business to profitability to avoid long term subsidy by other lines of business. That said, it is important that guidance not require submission of a detailed plan to a regulatory entity due to the risk of disclosure of competitive intelligence.

3.2.12 Risk Adjustment: Should this ASOP include any recommendations for appropriate data to use in developing weights for Medicaid programs? Given the differences in Medicaid programs between states and the wide range of utilization by different population groups, is it appropriate to use national weights for payment under an

established state program? Should the data used to develop weights reflect the mix of populations and covered services expected in the rating period, if differences are material?

3.2.14 Performance Withholds / Incentives: I welcome clarification regarding the need for attainable rates, given withhold return expectations for the program. Should an actuary consider other payment delays, such as a State delaying payment in one fiscal year to the next fiscal year for budget purposes?

3.2.16 Inaccurate or Incomplete Information Identified after Opinion or Rate Certification: I'm uncertain of the meaning of the first phase, "If prior to issuance.... he or she used inaccurate or incomplete information,". Does this mean that the actuary only needs to notify the principle if he or she receives new information in the course of developing a subsequent opinion, but not if the actuary receives new information and hasn't planned to issue a subsequent opinion or certification? If the principle submitted the certification to a Government entity, does the actuary have any duty to ensure the Government entity is notified of this new, material information? If so, the ASOP may need to clarify how changes that occur in the normal course of business (e.g. change in assumed provider payment level due to final contract negotiations following an MCO bid) vs. an error (e.g. missing base data) should be handled? If an actuary working for a state determines an error materially affects MCO payments, does the actuary have a duty to ensure the State rectifies the error and notifies CMS?

3.4 Documentation: Should documentation of capitation rates provided to contracting MCOs by a State, provide enough information to allow MCO actuaries to assess the reasonableness of the rates for a particular MCO? What "CMS regulations" should be considered in the actuary's documentation? Beyond 42 CFR 438.6(c), should the actuary consider the CMS checklist or other published documents?

Questions included in "Request for Comments" section of the Draft

1. I think the committee did a good job of balancing the needs of actuaries in both these situations.

2. Yes. It seems important that rates developed by actuaries should be actuarially sound, no matter the product line. If rates are not actuarially sound, it is important that this is disclosed and understood by all stake holders. Allowing actuaries to develop rates that don't meet basic soundness standards without disclosure may affect overall public trust in our profession. Given this, it would also be helpful to know if the ASOP applies to rates funded by the State only (no federal match) if these rates are included in the same contract as rates that fall under 42 CFR 438.6(c) or a CHIP program.

3. I believe that the definition of actuarial soundness is clear. This definition is consistent with the Practice Note and has been used extensively in current practice.

4. See my comments above.

5. I don't believe so.

6. See my comments above. There are a few areas where additional guidance could be helpful.

7. I believe it does.

Respectfully submitted,

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