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Actuarial Standards Board Comments
American Academy of Actuaries
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Submitted via email to comments@actuary.org

To Whom It May Concern:

The Association for Community Affiliated Plans (ACAP) thanks you for providing us with an opportunity to comment on the Exposure Draft “Medicaid Managed-Care Capitation Rate Development and Certification.” ACAP is an association of 57 nonprofit and community-based Safety Net Health Plans (SNHPs) located in 24 states. Our member plans provide coverage to 10 million individuals enrolled in Medicaid, the Children’s Health Insurance Program (CHIP) and Medicare Special Needs Plans for dually-eligible individuals.

This Proposed Actuarial Standard of Practice was posted on the Actuarial Standards Board website in December 2013. ACAP thanks the Actuarial Standards Board for its efforts to provide clear, practicable guidance for actuaries working for both states and Medicaid managed care organizations when developing and certifying capitation rates. We appreciate your willingness to consider our comments. ACAP developed our comments after consultations with actuaries of our member health plans, and our comments reflect the consensus of those discussions.

The Exposure Draft requested comments on seven specific questions. We have responded to these questions, and are also including comments in several additional areas of the proposed ASOP that we believe require clarification and/or modification.

- 1. This ASOP has been prepared to apply to both actuaries developing actuarial statements of opinion for a Medicaid MCO and to actuaries developing rate certifications under 42 CFR 438.6(c). Is this appropriate? Or should the ASOP be limited to actuaries developing rate certifications under 42 CFR 438.6(c)?*

We believe it is appropriate for this ASOP to apply to actuaries developing actuarial statements of opinion for a Medicaid MCO and to actuaries developing rate certifications, including those occurring under 42 CFR 438.6(c). **However, to avoid confusion, particularly with respect to some of the other activities with which plan actuaries can be tasked, such as developing IBNR certifications, we recommend that the proposed ASOP explicitly state that it applies**



only to managed care capitation rate development and certification as part of the bid process for Medicaid (and, see below, CHIP) MCOs. We believe that this clarification will dispel any uncertainty that might occur with respect to understanding that this ASOP applies only to the actuaries when they are developing and certifying the rates paid to MCOs by governmental entities – in many states this will be the actuary working for or on behalf of the state, but in some states it will be the plan actuary developing rate bids to present to the state.

2. *As written, this ASOP applies to Children’s Health Insurance Program (CHIP) managed-care capitation rate development. Is this appropriate?*

We believe that it is appropriate for the ASOP to apply to managed-care capitation rate development for both the Medicaid and CHIP programs. We recognize that the process for establishing managed care capitation rates in the CHIP program can vary from that in Medicaid but, to the extent that certifications of actuarial soundness are required, we concur that these standards should apply.

3. *Is the definition of “actuarial sound/actuarial soundness” in section 2.1 clear?*

We find the definition of Actuarially Sound/Actuarial Soundness in section 2.1 clear. We are particularly pleased to see the definition include the phrase “all reasonable, appropriate, and attainable costs.” In particular, use of the term “attainable” recognizes that plans operate in differing environments that need to be taken into consideration when developing actuarially sound rates. In addition, in situations where managed care rates are reduced to reflect desired program changes, it is important to recognize that such changes can take a period of time to implement and that implementation activities can result in increased costs in other areas. To not recognize these aspects would result in a rate which is not actuarially-sound. However, we do have some concerns about the definition’s ability to encompass unique risk sharing arrangements (see our response to question 6, below).

4. *In section 3.2.16, which discusses the actions required of the certifying actuary if the underlying data is identified to be inaccurate or incomplete, clear and appropriate?*

We believe that section 3.2.16 should use the word “omitted” and not “incomplete”. While we understand that “incomplete” is used in this circumstance to mean information that is missing (a covered service was left out of the calculation, for example) there is the potential for it to be misunderstood as not up-to-date and confused with “completion factors”. Because all data are incomplete in the prospective rate setting process, the term “omitted” may better describe this situation. Other than this change, we agree with the required actions of the certifying actuary as detailed in this section of the proposed ASOP.



5. *Does the ASOP restrict practice inappropriately?*

We do not believe that the ASOP restricts practice inappropriately.

6. *Does this ASOP provide sufficient guidance to actuaries practicing in these areas?*

We believe that this ASOP provides sufficient guidance in most areas. However, some aspects of the ASOP, particularly the definition of Actuarially Sound/Actuarial Soundness (section 2.1) and Base Data (section 2.2) may not adequately address new and unique reimbursement models, including patient centered medical homes (PCMHs), accountable care organizations (ACOs), and bundled payments. As unique risk arrangements become more commonplace, actuaries will have to incorporate this information into the base data. While the proposed ASOP may be sufficient for the rate development process for many states and plans today, we believe that the document needs to address how to incorporate these unique risk sharing arrangements to maintain relevance and usefulness.

7. *Does this ASOP provide sufficient guidance to actuaries in identifying and addressing potential inconsistencies in the expectations of actuaries working for Medicaid MCOs and those actuaries working for State Medicaid Agencies?*

We feel that the proposed ASOP addresses the potential inconsistencies and expectations for actuaries working for MCOs and for State Medicaid Agencies well. The only potential confusion is how it applies to MCO actuaries in states in which plans are not involved in the rate-setting process, but the clarification we proposed in our response to Question 1 would address this.

Additional Comments

Section 3.1 – Overview and Section 3.2.12 – Risk Adjustment

Section 3.1 states that the soundness opinion required by 42 CFR 438.6(c) applies to all contracted capitation rates, and that “the actuary is not certifying that the underlying assumptions supporting the certification are appropriate for an individual MCO.” We understand that it is unrealistic to require an actuary to certify that each and every rate is appropriate for each and every MCO. However, issues such as adverse selection, particularly for community-based safety-net MCOs affiliated with local hospitals and health clinics, can result in rates that are inappropriate for some plans when there is no mechanism to adjust for this issue. While many, but not all, states use risk adjustment to make rates appropriate for specific plans (as detailed in Section 3.2.12 of the proposed ASOP), current risk adjustment methodologies often lack the data quality, robustness and sensitivity on the extreme ends of the spectrum to effectively do so in all cases. **Therefore, we recommend that Section 3.1 of the ASOP explicitly state that rates should be made appropriate for each individual MCO through an actuarially sound risk**



adjustment process that is robust enough to reflect variations among the populations MCOs serve and the quality of data used.

Section 3.2.12 of the ASOP, in conjunction with ASOP number 45, The Use of Health Status Based Risk Adjustment Methodologies, addresses risk adjustment. We appreciate the inclusion of the fact that the use of a risk adjustment methodology should be influenced by program enrollment procedures that may affect differences in risk across MCOs or among populations used to develop the rates and to which the rates will be applied. **We recommend that Section 3.2.12 of the ASOP should go further, requiring actuaries to take the data quality, sensitivity and robustness of the risk adjustment model used by the state into consideration when certifying rates in order to adequately address adverse selection and other factors, including the provider network composition and payment rates, that can dramatically affect the composition of an MCO's enrollees. To the extent that the risk adjustment methodology does not fully address these issues, particularly for very high-cost or very low-cost beneficiaries, the actuary should use a rate development model that appropriately addresses these issues.**

Section 3.2.14 – Performance Withholds/Incentives

We were pleased to see the inclusion of Section 3.2.14 in the proposed ASOP. Currently, there are situations in which rates are established that are dependent upon the MCO earning back most or all of the withhold for the rate to fall within the actuarially sound range. Oftentimes, the requirements to earn back such a withhold are not reasonable and attainable, resulting in a rate that is not actuarially sound. We believe that Section 3.2.14 addresses this concern well and makes it clear that for a rate to be actuarially sound, it must still fall within the actuarially sound range with the withhold excluded.

Section 3.2.5 – Covered Services

Section 3.2.5 of the proposed ASOP states that the capitation rate should only include covered (i.e., state plan) services, with the option to include non-state plan services if they are provided in lieu of a state plan service. This section further states that enhanced or additional services (defined in Section 2.6) should not be included in the rate development. While we understand that this is drawn from regulation (42 CFR 438.6(c)(4)(ii)(A)), we are concerned that the definitions of state plan services (Section 2.17) and enhanced or additional services (Section 2.6) could cause confusion.

MCOs frequently provide non-traditional, patient-centered services that are not listed in the state plan to improve care and reduce costs that would otherwise be covered by state plan services. A classic example is providing air conditioning units to individuals with asthma or congestive heart failure, which has been demonstrated to reduce emergency department and inpatient utilization,



save money, and improve health outcomes. In our view, such a program/activity should be included in the capitation rate as a non-state plan service provided in lieu of a state plan service, because the emergency department visit and resulting medical care would have been a covered Medicaid benefit.

The opportunity for MCOs to provide non-medical services that impact health will only grow as MCOs take on populations with more complex needs since they are the most likely to benefit significantly from such services. The ability to use innovative, patient-centered services for the long-term supports and services population is particularly important, as non-medical expenditures to keep individuals in their homes improves patient choice and reduces costs associated with more-intensive health care services, including those of long-term care facilities.

Because “non-state plan service provided in lieu of a state plan service” is never defined, we are concerned that some actuaries may view a program like the one described previously to be an enhanced or additional service that should not be included in the capitation rate, while maintaining the assumptions about the savings and reduced utilization the program had previously achieved in the base data. **To ensure that MCOs are able to use innovative, non-traditional programs that obviate the need for or reduce medical costs (such as the air conditioner in the example above) and improve patient care, we believe that Section 3.2.5 should include clarification that such programs should be included in rate development as a non-state plan service provided in lieu of state plan services.**

Additionally, there is a need to clarify what enhanced or additional services are. Based on the examples provided in the definition in Section 2.6, we believe that a better term would be “value-added services” which plans explicitly negotiate with the state to provide above and beyond the contracted state plan services.

In addition, regardless of the ASOP’s final guidance on this issue, we believe that the example currently used in the explanation of what an enhanced or additional service is (Section 2.6) – that of Non-Emergency Transportation – is problematic. Given the nature of the other services referenced in this section, we believe that the drafters meant non-emergency transportation to be Non-Emergency *Medical* Transportation or NEMT, which is required to be provided to any Medicaid enrollee who is in need of the service. While it is true that NEMT can be provided either as a medical service or as an administrative cost, it is required to be provided when needed and should, to the extent that a MCO has a contract to provide this service, be included in any actuarially-sound rate. We recommend, therefore that this example be removed from this Section.

Section 3.2.1 – Form of the Capitation Rates (Single Rate or Capitation Rate Ranges)

While we understand that different states and actuaries prepare rates in different ways, we are concerned that states frequently, year-after-year, choose to pay the rate at the bottom of the rate



range. Rate ranges arise from the fact that reasonable actuaries will have differing opinions on future factors that affect the rate. This would suggest that the midpoint of the range, especially on rates over many years, is the best estimate. Thus, consistently paying only the lowest bound of the range creates rates that are no longer actuarially sound. For this reason, **we recommend including guidance to actuaries who certify rate ranges to communicate that the best estimate of an actuarially sound rate is the midpoint.** We also recommend that the ASOP require actuaries to provide the state sufficient information such that the state is able to justify their decision about what rate within the range to pay, and the effect of such state decision-making over multiple years.

Section 3.2.11 – Non-Medical Expenses

In Section 3.2.11 medical management costs are listed as a type of administrative expense. **However, ACAP and our member plans strongly believe that medical care and case management costs should be included as medical expenses. Such services are crucial to improving and maintaining the health and wellbeing of health plan members.** Furthermore, the ASOP includes medical and care management expenditures in the definition of Minimum Medical Loss Ratio in Section 2.11. In addition, case management costs are routinely considered medical expenses in other settings. For example, the Patient Protection and Affordable Care Act and subsequent regulations define medical expenses for the purpose of calculating Medical Loss Ratio for Qualified Health Plans as claims plus quality improvement activities, which include care and case management, as well as taxes, licensing and regulatory fees. All of these definitions appear to contradict the definition of administrative expenses as used in this Section and we recommend modifying the definition to be consistent with these other references.

Section 3.2.3 – Rebasing and Updating of Rates

This section outlines several of the major changes that can occur when updating rates, and recognizes that one of the decisions that actuaries need to make is whether to update rates or rebase them. **We recommend that this section be amended to specifically reference that actuaries should consider the impact of any program or benefit changes which may have occurred or which are scheduled to occur.** This issue has become increasingly germane as plans begin to see the impacts of program and benefit changes which are resulting from implementation of the Affordable Care Act.

Section 3.2.7.f – Other Base Data Adjustments: Program, Benefit, or Policy Adjustments

We recommend that Section 3.2.7.f should explicitly mention changes in medical practice, including newly approved drugs and devices, as a situation in which base data and capitation rates may need to be adjusted. When costly new treatments become available in the middle of a rating period and are not included in the base data, the financial impact on MCOs can be devastating and corrective action is needed within a reasonable time period, not during the



next rate development process. The importance of this issue, and the very clear need to ensure that MCOs are appropriately and timely reimbursed for extraordinary changes in medical practice and treatment, has grown exponentially as a result of the recent release of new, very expensive treatment regimens for the Hepatitis C virus, which occurred since the release of the exposure draft in December 2013, as well as since the certification of MCO rates for CY 2014.

Appendix –Current Practices

We appreciate the Appendix’s discussion of various techniques in which actuaries working on behalf of a state can participate to promote transparency when developing rates, including publishing data books, holding meetings with MCOs, and replying to questions from MCOs about the development process and assumptions and adjusting rates if appropriate. **We recommend that transparency should also be addressed in Section 3.4 of the ASOP**, and suggest, at a minimum, inserting the sentences: “Certifying actuaries working on behalf of a state should expect that MCOs will have the ability review the capitation-rate development process and assumptions and ask questions during the rate development process. They should also expect that a data book which includes baseline data, adjustments to the baseline data, actuarial assumptions, risk adjustment methodologies and data, and the development of capitation rates will be published.”

ACAP has also specifically addressed the issue of transparency of actuarial assumptions in our April 29, 2014 [letter](#) to the Center for Medicaid and CHIP Services. In that letter, we called for CMCS to incorporate the concept of transparency into its regulations by requiring states to disclose sufficient information to permit plans to replicate the rate-setting methodology and its underlying assumptions. To the extent that such a provision can be appropriately incorporated into the Actuarial Standard of Practice from an actuarial (rather than a state) perspective, we would also so recommend.

ACAP thanks the Actuarial Standards Board for its efforts to develop standards on this very important issue as well as its willingness to entertain our comments. If you have any additional questions or comments, please do not hesitate to contact Kathy Kuhmerker (202-204-2710 or kkuhmerker@communityplans.net).

Sincerely,

Margaret A. Murray
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