



Comment #13 - May 13, 2014 – 8:38 p.m.

Medicaid Managed Care
Actuarial Standards Board
1850 M Street, NW, Suite 300
Washington, DC 20036

Re: Proposed Actuarial Standard of Practice — Medicaid Managed-Care Capitation Rate Development and Certification

Dear Sir or Madam:

I am writing on behalf of Molina Healthcare, Inc. to offer comments and recommendations to the exposure draft of the proposed actuarial standard of practice, *Medicaid Managed-Care Rate Development and Certification*. We appreciate the Task Force on Medicaid Rate Setting and Certification’s efforts in developing this important Actuarial Standard of Practice (ASOP).

Molina Healthcare is a multi-state health care organization focused on government-sponsored healthcare programs for low-income families and individuals. Our 30-year history places us amongst the most experienced managed care companies serving the financially vulnerable. Today, Molina Healthcare provides healthcare assistance to approximately two million members in eleven states across the country. Molina also offers a qualified health plan on the Marketplace in the states where we operate a Medicaid health plan to better serve our members as they transition between insurance affordability programs.

Our comments are provided below in two parts: Part 1 contains comments and suggestions related to areas of particular interest requested by the task force; and Part 2 contains specific comments and suggestions identified by section referenced in the ASOP.

PART 1: REQUEST FOR COMMENTS

The Task Force listed seven questions of particular interest for consideration, and our comments are below:

1. The application of this ASOP to rate certifications for actuaries developing actuarial statements of opinion for a Medicaid managed care organization (MCO) and to actuaries developing rate certifications under 42CFR 438.6(c) is appropriate.
2. The application of this ASOP to Children’s Health Insurance Program (CHIP) managed-care capitation rate development is appropriate.
3. The definition of “actuarial sound/actuarial soundness” in section 2.1 is clear.

4. Section 3.2.16, discussion of actions required of the certifying actuary if the underlying data is identified to be inaccurate or incomplete, is clear and appropriate.
5. The ASOP does not restrict practice inappropriately.
6. The ASOP, in present form, does not provide sufficient guidance. The ASOP with revisions could provide sufficient guidance.
7. The guidance provided identifying and addressing potential inconsistencies in the expectations of actuaries working for Medicaid MCOs and those actuaries working for State Medicaid Agencies is sufficient.

PART 2: SPECIFIC COMMENTS

Section 2.1: Actuarially Sound / Actuarial Soundness

- The definition of “actuarially sound” should include mention of underwriting gain and/or risk margin, but is not cited in the proposed definition.
- We appreciate the inclusion of “government-mandated assessments, fees and taxes” as part of the definition of costs, particularly in consideration of the Affordable Care Act health insurer fee which impacts Medicaid health plans.

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

- Specific guidance should be provided for capitation rate ranges. It should be clear that the rates at both ends of the rate range must meet the definition of actuarial soundness and must NOT be constructed simply through aggregation of the best and worst case scenarios for each rating variable and assumption which would ignore the interdependence of the rating variables and assumptions leading to capitation rates that would not be actuarially sound.

Section 3.2.2: Structure of the Medicaid Managed-Care Capitation Rates

- Delivery case rates, low birth weight supplemental payments, and other supplemental payments should be mentioned in this section.

Section 3.2.5: Covered Services

- Non-state plan services “should” be included in the capitation rate if the service is provided in lieu of a state plan service. The current statement in the ASOP uses the word “may”.

Section 3.2.x: New Section Proposal – Network Re-pricing

- A specific section devoted to network re-pricing is warranted in the ASOP. Guidance should be provided regarding the applicability of the reference rate and fee schedule used to re-price claims. Specifically, the reference rate and fee schedule (i.e. 100% of Medicaid) must be representative of what is attainable for the MCOs. Furthermore, if a change is made to the reference rate and fee schedule, the change should be implemented prospectively to allow MCO’s time to configure payment systems and renegotiate any contracts that are not linked to the reference fee schedule. If changes to the reference fee schedule are implemented retrospectively and/or not announced with adequate lead time prior to the rate effective period, the actuary should consider

the expenses associated with the re-adjudication of claims and/or the time necessary for the MCO to renegotiate provider contracts in the capitation rates.

Section 3.2.8: Claim Cost Trends

- A list of items for developing claim cost trends should be added, which should include potential shifts in the mix of services as well as emerging technologies and pharmaceuticals.
- The actuary should be directed to disclose the basis of trend estimates such as the source, applicability, claims experience, time periods, trend surveys, etc.

Section 3.2.9: Managed-Care Adjustments

- The statement that "...adjustments should be attainable in the rating period..." is not sufficient. The following sentence provides better guidance, "If managed-care adjustments are included, the overall adjustments must represent what is attainable throughout the entire rating period, in the actuary's professional judgment."
- Other items to include for the actuary to consider in developing the managed-care adjustments:
 - Applicability and duration of specific continuity of care requirements which require MCOs to honor previous pre-authorizations and care regimens which would limit managed-care saving opportunities in the rating period.
 - Time required by MCO's to collect and evaluate health assessment data and experience to develop care management plans to achieve managed-care savings.

Section 3.2.11a.2: Non-Medical Expenses, Administration, Types of Administrative Expenses

- A section devoted to contract provisions should be added as a Type of Administrative Expense. Examples would include contract provisions related to expenses associated with mandatory staffing levels, health assessment requirements, administration of performance withholds, and financial reporting requirements.

Section 3.2.11b: Non-Medical Expenses, Underwriting Gain

- More details should be included regarding the type and level of risk borne by the MCO in consideration of risk-sharing arrangements, performance withholds, and minimum medical loss ratios in the determination of an appropriate underwriting gain provision of the capitation rate.

Section 3.2.13: Reinsurance, Risk Corridors, Other Risk-Sharing Arrangements

- A statement should be added recognizing that reinsurance, risk corridors and other risk-sharing arrangements will impact the level of risk borne by the MCO which the actuary should consider when determining the underwriting gain provision of the capitation rates.
- A comment should be added warning that risk-sharing arrangements structured to offer balanced protection, and not intended to impact the level of risk borne by the MCO, may actually change the MCO level of risk substantially if the probability of lower versus higher claims is not equal. The probability of lower versus higher claims

depends greatly on whether the capitation rates were based on aggressive or conservative rating assumptions or if the capitation rates were set at the low or high end of the capitation rate range.

Section 3.2.14: Performance Withholds/Incentives

- A statement should be added limiting the amount of performance withhold to no more than the underwriting gain component of the capitated rates.
- A statement should be added recognizing that performance withholds increase the level of risk borne by the MCO which the actuary should consider when determining the underwriting gain provision of the capitation rates.

Section 3.2.15: Minimum Medical Loss Ratio

- A statement should be added recognizing that minimum medical loss ratio provisions increase the level of risk borne by the MCO which the actuary should consider when determining the underwriting gain provision of the capitation rates.

Section 3.4: Documentation

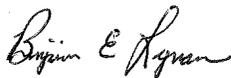
- MCOs should be considered as stakeholders and provided documentation to assess the reasonableness of the work.
- Documentation should be provided to stakeholders with enough time to adequately assess the reasonableness of the work prior to the capitation rate submission to CMS.
- If capitation rate ranges are developed, sufficient documentation should be provided for the upper and lower bounds of the capitated rate ranges to assess the reasonableness of work.

Section 4.2: Disclosures

- There are 2 subsections lettered “d”.

We appreciate this opportunity to provide comments and recommendations on the exposure draft of the proposed ASOP. Please feel free to contact me at 562-519-4904 or Benjamin.lynam@molinahealthcare.com if you require additional information.

Sincerely,



Ben Lynam
Vice President, Actuarial Pricing
Molina Healthcare