

Comment #2 – 2/9/14 – 9:27 a.m.

Nice to see that a practice note was provided on Medicaid. I work as a professor at Columbia University teaching health actuarial science and will discuss this note in our class. A couple of comments/consideration that actuaries may want to think about with this note are as follows:

- 1.) Financial Viability of Capitated Provider: A Medicaid health plan may capitate for specific providers or specialties. Actuaries may want to consider evaluating the feasibility of the capitation rate and the entity providing the capitation. If capitation rate is too low compared to underlying experience, then a potential that third party capitation vendor may not be able to meet its obligations. An actuary may want to consider evaluating the experience to see if capitation is reasonable and consider some level of financial review of the entity being capitated if capitation impact is material to financial statements. For example, a risk bearing provider group may need to be evaluated like an unauthorized or non-admitted reinsurer with health plan requiring a letter or credit, escrow, or some sort of reinsurance policy. If a shadow capitation arrangement or global capitation arrangement, then potentially a withhold provision on fee for service claims that are later trued up to a capitation. The more risk that an HMO pushes onto a provider group through capitation, the more potential exposure may exist.

The following concerns are needed pertaining to the provider group that receives capitation.

- a. Does the current capitation arrangement potentially jeopardize the provider group's financial position. If insolvent, then what happens. Providers group and healthcare systems might set up a separate contracting entity specific for capitation so if experience goes bad, it does not impact the system.
 - b. If capitating with a provider group that also provides capitation to other HMOs, then what happens if another HMOs deal goes bad (financial ruin), then how does the other HMO get impacted. There needs to be a certain level of ERM and financial analysis that an HMO needs to do with the provider group that does capitation or risk deals with other plans.
- 2.) Some capitation or subcapitation arrangements may not adjust the same as what the HMO participating in Medicaid would experience (e.g. risk adjustment). The subcapitation arrangement between the HMO and providers may not have a risk adjustment component and could be a global or flat cap rate reflecting Medicaid and potentially other products and locations.

Hope that this is helpful. Our organization does a lot of work in the Medicaid including helping HMOs with filings and reserves, third party capitation vendors in capitation determination and reinsurers and private equity firms in assessing arrangements around

organizations that assume risk in healthcare including Medicaid (e.g., HMOs, risk bearing provider groups that take capitation).

If you want additional comments, then please let me know. My contact information is below. Thank you and best wishes.

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