

Comment #15 – 5/15/14 – 1:01 a.m.

I appreciate the opportunity to comment on this important development in Medicaid managed care industry that will shape sustainability and longevity of many current and future Medicaid programs for years to come.

I would like to thank all that has worked on development and commentary of this Actuarial Standard of Practice and hope that my considerations of the draft proposal will lead to additional discussions by the experts and parties involved and will make standards more flexible and adaptable to future active use in rate-setting discussions.

There are two main areas of potential considerations – revisions to Scope, Definitions and commentary of specific sections of Analysis of Issues and Recommended Practices.

I. Scope:

1.2. Scope:

- Applicability of this standard to both Medicaid and CHIP programs is appropriate. However, recent developments in Medicaid products raise questions about further applicability to new products using Medicaid funding mechanisms but not called Medicaid (e.g. Medicaid ACA Expansion blocks that are not called Medicaid explicitly, added or not added to existing Medicaid managed care state contracts). Given specific uncertainty and regulatory risks related to these new populations, actuarial soundness plays vital role in sustainability and longevity of these expansions. Additionally, recent introduction of Dual Demonstration Projects, raise another question of actuarial soundness and this ASOP specifically – if it applies to Medicaid rate component only or applies to an overall Dual Demonstration Premium rate or does not apply at all.

II. Definitions:

2.1. Actuarially Sound Actuarial Soundness :

- This definition is currently omitting two important component of actuarial soundness definition from CMS regulation 42 CFR 438.6(c) – sections A. and C. of actuarial soundness definition that requires rates to be “ developed in accordance with generally accepted actuarial principles and practices;” and “having been certified by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board”. While this may appear redundant and assumed, it is a critical link to other ASOPs and general principles followed by actuarial profession. While this currently is maintained as a requirement in CMS Checklist (regulation 42 CFR 438.6(c)), if that regulation is revised, this important component of definition may disappear completely. It is especially critical to maintain language about “generally accepted actuarial principles and practices” to allow for flexibility in new products, risk considerations and approaches that Medicaid managed care industry experiences with rapid growth in types of populations covered, product types or

new regulatory constraints imposed. Since development of specific ASOPs to address these considerations may lag for several years, this general reference to “generally accepted actuarial principles and practices” will remain relevant for years to come.

- This definition is also currently omitting references to both regions and rate-cells and requirement to be actuarially sound for both elements. This is currently reflected also in CMS Checklist (regulation 42 CFR 438.6(c) – Attached) in section (3), Requirement for actuarially sound rates, that lists both “region/locality” and “rate-cell” as required actuarially sound elements. This is important with introduction of new populations placed in new rate-cells or Medicaid MCOs being present in specific regions and localities. Not having ASOP and actuarial soundness requirement extend to regions and rate-cell places MCOs with disproportionate rate-cell and regional exposure to undue pricing risk
- This definition refers to an important “attainability” criteria as part of actuarially soundness definition – it is important to attempt to define attainability as a separate Definition. For example, it can include requirements that “attainable” must be observed and quantified change or improvement in same state and population by another MCO. If results were observed in a different state or population, this study needs to be shared with MCOs and adjusted for populations, technical requirements/benefits of the program as well as differences in environmental factors including provider access and regulatory constraints that may adversely affect attainability of savings in a specific state

2.7. and 2.16. FQHC/ RHCs:

- While FQHC/ RHC - important type of providers with notable unit cost differences is considered in Definitions section, CAHs (Critical Access Hospitals) with equally material unit cost and regulatory impact are not included nor considered

2.10. Medical Education Payments:

- This important section may need to extend to all types of “supplemental payments” including various potential entities involved. It also needs to specify that not only it may be included in capitation rates or made directly to providers but also needs to be clearly specified as a component of the capitation rate and ensured to be consistent with expected payments to be made in the rating period. Additionally, in the event that supplemental payment liability specific to each MCOs varies, allocation method of supplemental payment needs to be appropriately developed and periodically reconciled to ensure that additional risk factors or gains are not introduced by this component of rate-setting.

2.15. Risk Adjustment:

- This definition appears to imply that risk adjustment takes the form of the usual morbidity based diagnosis factors (CDPS, etc) and does not include other elements of risk adjustment that is important and present in Medicaid managed care programs (often well before introduction of morbidity based risk adjusters). These risk adjustment elements include delivery rate components (e.g. kick payments), low birth weight payments (NICU kicks), high risk pools (between MCOs) or reinsurance / high risk pools

between state and MCOs. These elements would also benefit from additional definitions in this ASOP as they are gaining popularity. Similarly, risk corridors, gaining popularity for expansion populations, are not defined in this ASOP

III. Analysis of Issues and Recommended Practices:

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

- This section would benefit from additional consideration for required disclosure: either in disclosure of width of the rate ranges, if the width of the rate ranges was changes in current rate-setting or in disclosure of the position within the rate range to MCOs

3.2.2. Structure of the Medicaid Managed Care Capitation Rates:

- It is important that MCO differences are considered in this section among characteristics that may need to define rate structure. One of the common differentiating factors between MCOs are the network differences and resulting selection rates by members with some MCOs consistently attracting disproportionate share of active selecting members seeking utilization and availability of certain type of providers limited in networks of other MCOs. While demographic and morbidity based risk adjustment factors help mitigate some of the resulting differences, in states without implemented morbidity based risk adjusters, selection versus auto-assignment status may be considered as one of the rating variables, if notable differences are observed in any given state with resulting distortion in financial performance of the MCOs.

3.2.4 Base Data and 3.2.6. (c) Incomplete Base Data Adjustment:

- This section appears to imply that main source of incomplete data is the incurred but not reported claims, outstanding settlements and claims in settlement. Since Section 3.2.4 defines Base Data as potentially based on encounter data, it is important to consider another component as consistently lower encounter data based experience as compared to audited financial statements and submissions by MCOs. Specifically in occasional instances of material documented and consistent variances (as much as 10-20% for some categories of service), an adjustment must be made to bring encounter data used to reasonable documented level that ties to audited statements and not affected by procedural constraints such as state encounter system setup or definitions and resulting rejection rates for submitted encounter data elements.
- Similarly, section 3.2.4 may benefit from additional guidance when encounter data is allowed to be used for the overall spending level determination (i.e. overall pmpms) rather than limited analytical projects requiring claims level detail.
- Base Data Period Adjustment section may benefit from further definition and considerations for situations like state fee schedule change (if it falls under program change definition and automatically requires base data adjustment) and if it includes change in basis of the reimbursement to providers defined by the state (conversion of different fee schedule type or settlement process, etc).
- Historical Base Data Period Adjustments may also benefit from additional consideration if actuary is required to consider and re-evaluate earlier made assumptions about expected cost impact of fee schedule, benefit or other program changes. It is equally critical if this re-determination of true impact is applicable to change in basis of

reimbursement (conversion to different fee schedule) and consideration for disproportionate regional or rate-cell impact relative to earlier made assumptions incorporated in premium rates and costs. This consideration further raises question if discovery of material deviation from original pricing assumptions has to lead to retroactive adjustments and re-evaluation of actuarial rate sufficiency. It is notable that this is particularly important in an environment where minimum MLRs apply and it is critical to ensure rate adequacy and appropriate allocation of revenue by rating period.

3.2.11 Underwriting Gain:

- This section may need to consider recommendation for correlation of level of underwriting gain assumption with the level of risk and uncertainty of given populations or Medicaid program design for new programs and markets and ability for sustainability of existing MCOs in mature managed care programs.

Thank you again for your consideration.

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