January 14, 2011

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Re: Responses to questions regarding CMS' rate-setting checklist

Dear Ms. Dobson:

On behalf of the American Academy of Actuaries'[1] Medicaid Work Group, thank you for the opportunity to re-open a dialogue on the CMS rate-setting checklist, the Academy's August 2005 practice note, *Actuarial Certification of Rates for Medicaid Managed Care Programs*[2], and the Actuarial Standards of Practice (ASOPs).

There is a long history of cooperation between the Academy and CMS (and its predecessor, the Health Care Financing Administration) on regulatory issues that concern actuarial practice. We look forward to continuing that tradition with you and the rest of CMS in 2011 and beyond.

We respond below to each of the CMS questions (dated Nov. 3, 2010) that were posed to the Academy. We have repeated and bolded the original CMS questions just prior to each of our responses.

1) **In 2005, the American Academy of Actuaries (Academy) recognized CMS' use of the checklist as a rate-review tool in the Health Council Practice Note. The certifications provided by States however, often are not transparent in how the requirements were applied in the rate development process. How can the Academy address these content inconsistencies that are communicated in actuarial certification documentation?**

   Each state Medicaid program is unique. So, too, is each state's Medicaid managed care capitation rate development process. Although core principles, overall approaches, considerations, and practices should be consistent, resources and data available for each state vary widely. States have a vested interest in receiving capitation rate approval from

[1] The American Academy of Actuaries is a 17,000-member professional association whose mission is to serve the public on behalf of the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
[2] American Academy of Actuaries, *Actuarial Certification of Rates for Medicaid Managed Care Programs*, practice note (Aug. 2005): https://www.actuary.org/pdf/practnotes/health_medicaid_05.pdf.

their designated CMS regional office. States and their actuaries, for the most part, historically have taken what could be described as a responsive role regarding the actuarial certification submissions to CMS by updating the prior year's certification. The states and their actuaries typically have utilized the same format, updated for applicable data, information, and contract changes, as in previous year(s). States then made further revisions based upon CMS regional office feedback, carrying these documentation adjustments forward to the following year's certification. Some actuarial certifications vary based on whether they are filed in a "rate update" year or are a "rebasing" of the rate-setting process. Certifications are supposed to provide appropriate detail of the summarized base claims data, the assumptions used to adjust the data, and the final rates. The documents also include discussion of the source(s) of each of these elements.

Efforts to increase review standardization at the CMS regional office level will be a welcome development in helping achieve the desired goals of increased transparency and consistency. Gathering "best practices" from across the regions should prove highly beneficial. Some regions, for example, require a numbered cross-walk from the certification document to the applicable CMS rate-setting checklist section or subsection. An actuarial memorandum accompanying the certification potentially could be required. CMS might define the information required to be included in the memorandum. A centralized database providing rate certifications and supporting documents given to CMS in the rate-setting process would encourage greater consistency among states, allowing actuaries to review the rate certifications from state-to-state. All of the ideas discussed above are examples of approaches that could help increase confidence in the different rate-development processes utilized.

2) **GAO noted that the 2005 Practice Note is nonbinding guidance to actuaries certifying actuarial soundness. However, practice notes do not have the same standing as a Standard of Practice in determining what constitutes generally accepted actuarial principles and practices. ASOPs are considered part of actuaries' professional code of conduct and have the highest standing. In contrast, practice notes are not a definitive statement as to what constitutes generally accepted practice. Would the Academy be willing to make the necessary adjustments to turn the practice note into an ASOP?**

As background, there are references within *Actuarial Certification of Rates for Medicaid Managed Care Programs*[3] to ASOPs that are binding on an actuary certifying Medicaid rates or rate ranges. An ASOP does not have to explicitly mention a specific area of practice to be applicable to it. Those referenced ASOPs include, for example, Nos. 5, 12, 17, 23, 41, and 42. The Actuarial Code of Professional Conduct clearly applies as well. So the statement on Page 8 in the August 2010 GAO report (GAO-10-810)—that there is no Actuarial Standard of Practice (ASOP) that applies to actuarial work performed to comply with CMS's regulations—is factually incorrect.

The practice note does have several internal references to its "non-binding guidance" nature. Academy practice notes, however, are more significant perhaps than CMS (or the

[3] Ibid.

GAO) may realize. They provide important information on current and emerging professional practices in selected actuarial areas. While practice notes don't have the force of an ASOP, they provide valuable insight to actuaries on the practices in which their peers are engaged.

The Actuarial Standards Board (ASB) has the authority to promulgate new ASOPs. Although it is housed and supported by the Academy, it operates with a great deal of autonomy. Across all actuarial disciplines (including casualty, health, life, pension) the ASB currently has promulgated fewer than 50 ASOPs. There are no specific ASOPs, for example, for non-Medicare individual, Medicare, military, or large-employer health benefit plans. The development of a new ASOP is a carefully considered and time-consuming process. In determining whether a new ASOP is warranted, one of the factors the ASB likely would consider is whether the existing ASOPs adequately address this practice area or whether there are gaps that need to be filled by a new ASOP.

The phrase "emerging area" has been used to describe, in part, the reasons behind opting for the practice note approach in 2005, instead of seeking the development of a new ASOP. Although the practice note was published in August 2005, only two years after the most recent CMS rate-setting checklist (dated July 22, 2003), the principles, practices, and considerations of those individual Medicaid actuaries and their peers involved in the development of the practice note literally reflected 10, 15 (or more) years of Medicaid managed care rate-setting experience, dating back to the late 1980s and early 1990s. Those actuaries responsible for the development of the 2005 practice note possessed a considerable breadth and depth of Medicaid rate-setting experience and expertise.

Based upon the CMS request, GAO concerns, and the desire of a significant proportion of our current work group members, the Academy Medicaid Work Group will be updating the 2005 practice note, with the intention of including (among other updates) more explicit reference to the various ASOPs that apply to Medicaid work.

The Academy's Medicaid Work Group is committed to referring the question of development of a Medicaid/CHIP-specific ASOP to the ASB, with a recommendation that the ASB consider whether an ASOP is needed in this area. While the work group in general supports pursuit of an appropriate Medicaid/CHIP-specific capitation rate development and certification ASOP, the final decision is not in our hands. It belongs to the ASB. Should the ASB decide to develop such an ASOP, the process of research, drafting, exposure and comments, and revisions can take up to a year or more in order to develop the ASOP.

3) **While §438.6 governs MCO, PIHP and PAHP contract requirements, other Federal regulations govern the conditions for federal financial participation (FFP). How does the actuarial process consider the limitations that are inherent in the rate development process? What are the Academy's communication requirements to document those considerations?**

We interpret these questions as application of fee-for-service (FFS) and other non-438.6 Medicaid rules to managed care capitation payments. For example, to what extent are the Medicare UPL (upper payment limit) unit-cost limitation, state plan reimbursement rates, and funding sources (e.g., taxes, intergovernmental transfers, certified public expenditure rules, etc.) applicable and how are they handled?

The actuarial rate development and certification process for Medicaid is required to comply with all applicable federal and state laws, rules, and regulations. To the extent principles and practices in the development of actuarially sound Medicaid managed care capitation rates may conflict with any applicable federal or state law, rule, or regulation, the state should consult with actuarial and legal resources to resolve the conflict. Should the issue remain unresolved, communication with CMS typically would be strongly encouraged.

An excellent example of this process, even within 42 CFR 438.6, concerns the development and evaluation of risk corridors as written within the final rule. Risk corridors can be valuable financial tools. The risk corridor evaluation limits, however, can be viewed by states and health plans as highly problematic. CMS regional offices have shown excellent flexibility in working with states and their health plans to implement such arrangements in which they were deemed as beneficial for all parties.

ASOP No. 41, *Actuarial Communications* (revision pending), adopted by the ASB in March 2002, addresses actuarial communication, which is defined as: "A written, electronic, or oral communication to a principal or member of the intended audience by an actuary with respect to actuarial services." The principal is defined as "an actuary's client or employer." There certainly can be others in an intended audience of actuarial communication. "Intended audience" is defined as: "The persons to whom the actuarial communication is directed and with whom the actuary, after discussion with the principal, intends to communicate." Unless otherwise specifically agreed to, the principal is always a member of the intended audience. In addition, other persons or organizations, such as regulators, policyholders, plan participants, investors, or others, may be designated by the principal, with consent of the actuary, as members of the intended audience. As part of the actuarial communication, any limitation or constraint should be disclosed when describing the scope of the assignment.

4) **Standard ad-hoc/summary reports as limited verification. GAO has criticized CMS for accepting State assurances of the soundness of rates. While CMS does need better documentation, not all regions have the staff expertise perform a thorough review on the rates. Would it be reasonable to ask for summary reports for purposes of limited verification? For example:**
   - **List of data edits that the state uses in their MMIS system to reject or accept claims for payment (some edits ensures removal of unallowable services and/or duplicate claims among many others for quality of the data)**
   - **Pertinent Claims Data Codes used: medical procedure codes, diagnosis codes, and categories of eligibility codes that are contained in the claims data. May help reveal upfront unallowable services or eligibility groups being included.**

- **Data adjustments Report. Types of data or payments the state excluded from the FFS data being used to come up with the projected rates so that we are informed early/upfront.**

Some or all of these reports might assist us in verifying items AA1 – AA5.

We are also interested in learning more about the State's data quality efforts, such as:

- **Efforts to reconcile financial data used to set rates to enrollment data ensuring that data is only from eligible individuals.**
- **Efforts to compare health plan enrollee data to state data to ensure cost report reflect all eligibility groups under MCO contract.**
- **Review of encounter data on a quarterly basis to identify duplicate or high cost claims which are returned to health plans for explanations and/or adjustments as necessary.**
- **Audits or annual validation studies of encounter data, which may include tracing encounter data submitted by health plans to information n Medical records.**
- **Efforts taken by state to review rate-setting process, appropriateness of data and if data still reflects the experience of the state's managed care population.**

If the state provides any of the reports above, it may be helpful to ask the state to provide a description of parameters used by the state in the development of these reports.

Cost and eligibility data and information unquestionably are critical elements in capitation-rate development. They not only are the starting point in the process, but also are utilized in components such as program change evaluation, claim cost trend development, managed care cost efficiency, effectiveness opportunities, etc. But while the data and information play critical roles, there are multiple sources, assumptions, analyses, computations and decisions that lead to the development of actuarially sound[4] capitation rates or rate ranges. CMS could provide standard guidelines and/or require the state to describe what they did to verify the data was correct before the state provided it to the actuary. CMS separately could require a standardized summary of what the actuary did to verify that the data received were reasonable and appropriate for rate setting.

As referenced within the practice note, there is an ASOP addressing the binding guidance to an actuary on the topic of data—ASOP No. 23, *Data Quality*—adopted by the ASB in December 2004.[5]

ASOP No. 23 has four sections: 1. Purpose, Scope, Cross References, and Effective Date; 2. Definitions; 3. Analysis of Issues and Recommended Practices; and 4. Communications and Disclosures. The ASOP gives guidance to the actuary on the following:

[4] Please refer to the current Medicaid-specific information on the term "actuarial soundness" in the 2005 practice note, *Actuarial Certification of Rates for the Medicaid Managed Care Program*.
[5] http://www.actuarialstandardsboard.org/asops.asp

- Selecting the data that underlie the actuarial work product;
- Relying on data supplied by others;
- Reviewing data;
- Using data;
- Making appropriate discloses with regard to data quality.

While the actuary rightly retains significant responsibilities in the data area, Section 3.6 of ASOP No. 23 describes the limitation of the actuary's responsibility, "The actuary is not required to do any of the following: a. determine whether data or other information supplied by others are falsified or intentionally misleading; b. develop additional data compilations solely for the purpose of searching for questionable or inconsistent data; or c. audit the data."

Each of the bullet-point comments within Question 4 would enhance CMS' confidence in the underlying quality, integrity, and accuracy of the data. Increased communication between the state and CMS should provide greater assurance that the data being utilized are valid and reliable. Challenges as simple as capitation rate data being analyzed on a date-of-service basis, as well as many state summary reports being developed on a date-of-payment basis, would need to be overcome for those state standard/ad hoc summary reports to be strong verification tools. CMS and the state(s), however, would need to determine what existing or new reports are reasonable and appropriate, given limited resources of personnel and time on both sides.

It might also be useful for CMS to hire at least one or two credentialed actuaries with relevant Medicaid experience to ensure all CMS staff are appropriately trained on Medicaid managed care rate setting principles and practices. These actuaries also could be available as internal consultants to the regional offices.

5) When are retroactive rate increases appropriate/inappropriate? What are the time limits on how far back a retro rate increase should be allowed? What factors should we consider when reviewing them? Should we require a new rate certification, if it is still within the range? What is the appropriate course of action when a rate certification expires and the contract is extended because negotiations of the new contract are not yet concluded?

Retroactive rate adjustments (both increases and decreases) resulting from informal or formal (legal) disputes are subject to timeframes determined by state or federal law.

If the state or actuary (working for a state or health plan) becomes aware of a significant omission or error in the original rate development due, for example, to missing data, miscalculation, or misinterpretation of the application of the contract between the state and the health plan, a retroactive rate adjustment should be considered. Federal or state mandated benefit or fee schedule changes that are determined to have bearing on the capitation rates are additional examples of situations to be considered for retroactive rate adjustments.

Other retroactive rate adjustments, such as implementation of new or increased provider taxes or fees or legislated increases (and the retroactive effective date) to provider reimbursement by health plans, typically are negotiated between the state and CMS, with the other affected parties working through the state. The actuarial function usually is limited to estimations of the change's financial impact and incorporation of those estimates into the capitation rates, once the state and CMS reach agreement that the change is consistent with all applicable laws, rules, and regulations, as well as program/policy objectives. In some instances, the actuary could be requested to provide an opinion as to the resulting capitation rates' relative cost relationship to Medicare or commercial payments in order to determine reasonableness.

A new or amended certification is likely desirable for documentation purposes, although it can be costly to the state. Thus some level of materiality of the change should be considered.

Should a contract and certification expire, with a new contract not yet agreed to due to ongoing negotiations, the state typically would continue to pay the current capitation rates. The state would provide assurance that once the new contract was in place, it would pay capitation rates within the new actuarially sound rate range, effective from the start of the new contract. Other financial arrangements, provided they are acceptable to all parties (health plans, state, CMS), also could be appropriate, for a variety of reasons.

6) **AA.1.2 & AA1.4—Can these sections be interpreted to require a fiscal impact report from the State? An impact statement similar to what we see on the finance side for new cost allocation plans submitted where the state or its contractor provides a fiscal impact report indicating where the increases and decreases took place, overlying assumptions, and why the costs changed from the prior year.**

   Item A.A.1.2 of the July 22, 2003 CMS rate-setting checklist references projection of expenditures. The state often provides a supplemental schedule containing the historical information the CMS Regional Office has requested. The rate certification document and any attached schedules presumably would describe and quantify the material components of the overall rate change. If that has not historically been requested, the component impact analysis could be contained within the certification, or duplicated within the state's supplemental schedules and exhibits.

7) **AA.2.2 and AA.3.14—These sections include comments that address an actuary's assessment of plan financials and encounter data. CMS is considering removing these statements. Can the actuaries provide more information on how they use the data in rate-setting? Adequacy and accuracy of base year data for rate-setting continues to be the subject of A-133 audit findings? The States need to be held more accountable for the accuracy of the data; how might we best accomplish this?** Within the July 22, 2003, CMS rate-setting checklist, AA.2.2 addresses dual eligibles and AA.3.14 addresses incomplete data and the application of completion factors. Without knowledge of the specific sentences referenced, we would caution against removal of statements concerning actuarial assessment of health plan encounter data and financial

statements as data sources. As described in AA.2.0, the state, its actuary, and the CMS regional office have the same goal in determining the most appropriate data to use in the capitation rate development process. This often can be a combination (given each can have existing limitations) of health plan encounter data, health plan financial reports and statements, and FFS data.

As described in the answer to Question 4, cost and eligibility data and information are unquestionably critical elements in capitation rate development. They not only are the starting point in the process, but also are utilized in components such as program change evaluation, claim cost trend development, managed care cost efficiency and effectiveness opportunities, etc. As mentioned above, however, while the data and information play critical roles, there are literally tens, hundreds, or thousands of sources, assumptions, analyses, computations, and decisions that lead to the development of actuarially sound capitation rates or rate ranges.

Increasing the accountability of states, their actuaries, and their contracted health plans with regards to accuracy and adequacy/completeness of data is a highly desirable goal. Some states have begun formal encounter data and financial report comparisons at the category of aid and category of service level. These comparisons can uncover underlying issues to be resolved. Audits of health plans focused on one or several topics can provide further information with regard to the appropriateness of these historical expenses for base data use. Additional reports and periodic audits are not without potentially significant cost, and so the benefits to be gained must be weighed in comparison to the time and money resources expended.

8) **A.A. 3.0. Adjustments to Base Year Data—**

   a. **Pharmacy rebates are noted as an adjustment that would result in a decrease in capitation rates. This type of adjustment is not discussed in any subsequent section of the 2003 checklist; however, there is increased interest in this adjustment element as a result of ACA Section 2501 which permitted States to access rebates on MCO-paid drugs. Can you discuss how rebates (both State and plan-negotiated) are now addressed as an adjustment, and how that will change. How should we reflect those nuances in the checklist?**

      Pharmacy manufacturer supplemental rebates to health plans are one of the most challenging rate-setting assumptions for states. Due to the nature of these rebate programs, the amounts can have a relatively long lag time to payment and vary from year to year. The relationship of rebates to other pharmacy pricing components is not very transparent. Without an audit, it is impossible to verify health plan reported figures. Without audit of the Pharmacy Benefit Manager (if applicable), it is also not clear as to how rebate contracts are paid.

      With the Affordable Care Act (ACA), it would appear likely that rebates negotiated by health plans would decrease significantly, although probably not be entirely eliminated. Several states proactively have revised the assumptions utilized. But, given market forces and the competitive nature of the

pharmaceutical industry, many states have requested their contracted health plans provide documentation through various survey instruments as to the exact change in the contracted rebate amounts or percentages. The gathering and evaluation of this documentation has, in several instances, left no adjustment to current assumed rebate levels as a placeholder. As with any program change, if not already handled via revised assumption(s), states and their actuaries clearly will need to address this issue definitively. And if an adjustment is determined appropriate, states and their actuaries will need to account for the March 2010 effective date. Depending on population and service category mix, pharmacy rebate offsets currently could account for approximately 1 percent, 0.5 percent, or less of total claims cost.

It is worth noting that when adjusting Medicaid managed care data for rebates or rebates lost, these are the amounts applicable to the managed care plans—and not those received by the state. For rate setting, the actuary would estimate the supplemental rebates "earned" in the prospective contract period.

b. We have been informed that some actuaries apply a 'managed care adjustment' to take into account the level of efficiency a plan should be operating at. How common is this type of adjustment? Are there generally accepted efficiencies that can be applied? If not, how are such efficiency factors arrived at? How do we ensure that they are not simply a way for States to drive down rates by a specific percentage?

Managed care savings adjustments when FFS are the base data are common and accepted. Disagreements can and do arise over the amount and/or attainability timing of the savings estimates.

Managed care efficiency and effectiveness adjustments to existing health plan data are probably the most contentious issues (including claim cost trend and administration) among actuaries familiar with Medicaid. This type of adjustment, in varying forms and amounts, has been in place for nearly10 years in New Jersey, for example. As states look to enhance value-based purchasing and hold health plans increasingly accountable financially, and as they labor to address state budgetary pressures, these adjustments are becoming increasingly common.

A significant proportion of Medicaid actuaries believe that state administrators and regulators, as well as state and federal taxpayers, have the right and flexibility to demand optimal achievable value from health plans. These actuaries believe that the state may—or may not, for various reasons—choose to fully exercise that right, and that the state may change, from year to year, the degree to which it fully exercises that right. For ease of discussion, these positions will be considered a "state approach."

Conversely, a significant proportion of Medicaid actuaries believe that many, if not all, of the efficiency and effectiveness adjustments incorporated by states are

unjustified or overstated, and fail to account for the considerable limitations, restrictions, and barriers inherent in Medicaid (compared to commercial health insurance). These limitations include but are not restricted to: administration restrictions imposed by the state; attitudes and approaches of the provider community; limitation on health plan managed care techniques imposed by the state; and length of time managed Medicaid has been in place. For ease of discussion, these positions will be considered a "health plan approach."

There are no generally accepted efficiency adjustments currently being applied. Those that favor the "state approach" commonly consider clinically-based data and information-driven efficiency and effectiveness analyses including: reduction of low-acuity non-emergent ER visits; reduction of potentially preventable inpatient admissions; reduction for pharmacy pricing and utilization measures, such as maximum allowable cost analysis and preferred drug lists; reduction for cesarean-section prevalence targeting; and reduction for over-utilization of specific radiology services. (Savings typically implicitly or explicitly are modeled within the rate-development process by increased utilization of primary care or pharmacy or both.) Other data- and information-driven analyses include: provider re-contracting opportunities, third party liability, coordination of benefits, overpayment recoveries and collections, fraud and abuse collection enhancements, and reduction for hospital acquired infections. These are a few examples likely to be considered in the future. Under the "state approach," these types of analyses are critical tools as part of the next-generation of Medicaid managed care capitation rate development.

Those that favor a "health plan approach" have questioned the applicability of the efficiency and effectiveness adjustments, believing it is often unclear: how the adjustments are developed and what their relation to Medicaid populations is. They also question whether efficiency and effectiveness adjustments are attainable in the upcoming contract period, and whether the state actuary accounted correctly for health plan managed care impacts on reducing claim cost trend, thus in effect double-counting applied savings.

Without question, these types of managed-care adjustments, if applied, reduce capitation rates. While less common, there certainly have been instances where managed-care adjustments have been used to raise rates to keep a health plan on solid operating footing, thus furthering overall program goals. Reduced, or more likely smaller increases to, Medicaid managed care capitation rates, provide some relief to state and federal budget deficits. Page 12 of the August 2005 practice note states that, actuarially sound rates or ranges of rates "depend on the benefits provided and the population covered. These rates are normally independent of budget issues unless benefits or populations change." Also on Page 12, "Budgetary constraints may influence the selection of certain assumptions toward the low end of the range. However, the actuary would usually be prudent to select assumptions that are individually reasonable and appropriate when deriving the final premium rates." If a state supports Medicaid managed care, it typically and

for a variety of important reasons, does not want to see a health plan depart. Health plans typically and for a multitude of important reasons similarly do not want to exit a market. Final determination in specific cases of rate-setting "prudence" or lack thereof, and its resulting impact on state and health plan goals, could be a matter for the courts, should disputes between the parties go unresolved.

The rate-setting actuary certifies the total capitation rate or rate range, and not individual components of the rate. He/she certainly does not advise the health plan on where its resources are best deployed. Rate-setting actuaries, however, should provide appropriately detailed information in their rate certification or supplemental documentation on how they developed any managed care efficiency and effectiveness adjustment(s). Depending on the approach, these details could include the expectations of how the health plan(s) might become more efficient, which categories of service would be expected to be affected, why the adjustment(s) are applicable in the rating region or state, and how limitations, restrictions, and barriers were considered.

Increased state and health plan transparency and collaboration would help to safeguard against any misapplication or misuse of managed care efficiency and effectiveness adjustments.

9) **AA.3.7. FQHC and RHC reimbursement—Bruce Johnson replied to a question by Milliman about some States requiring the plans to pay the annual cost settlements to the FQHCs and RHCs by stating that "States may require the entity to pay the annual cost settlement. However, the State must still do the required annual reconciliation." Milliman suggested, "If entities are required to pay the settlements, rates should be differentiated between entities based on their levels of reliance on FQHCs/RHCs." Should States be allowed to require entities to pay the annual cost settlements? Is there validity in the notion of varying rates based on their use of FQHCs/RHCs?**

States requiring entities to pay the annual cost settlement is more of a policy question than an actuarial question. Is there true risk? Is that risk controllable? If not, it is debatable whether those costs ideally would reside within a managed care risk contract. Should the policy decision be made to have entities pay the annual cost settlements, then the notion of varying rates based on the plan's membership use of federally qualified heath centers/regional health centers (FQHCs/RHCs) clearly would be valid. With the state having the risk for the wrap-around and reconciliation however, it may not be necessary.

While health plans could do this, operationally it is likely to be very challenging. Health plans would expect to receive additional administrative dollars, as well as an assumed load for profit/contribution to surplus, if requested to provide this service under their contract with the state.

CMS may want to consider allowing a state to negotiate, with a health plan or all health plans, a method that would allow a pass-through of the wrap-around payment to the health plan, so that payments to the FQHC/RHC are based on actual health plan experience.

To minimize complexity challenges to current levels, we believe it remains most efficient for the state to retain responsibility for FQHC/RHC cost settlements.

10) **AA.3.9. Copays—An actuary recently inquired whether it would be allowable to make adjustments in the rates for the expected copays, if it is reasonably certain that the plans will not be able to collect 100% of the copays. CMS regulations say the rates must be calculated as if 100% of copays or cost sharing were collected. How can this inconsistency be reconciled in order to ensure actuarial soundness if it is clear that the plans would not be able to collect 100%? Would it be beneficial to add in Step AA 3.9 a reference to 42 CFR 459(a) which indicates "there is no FFP for cost sharing amounts that recipients should have paid as enrollment fees, premiums, deductibles, coinsurance, copayments or similar charges under §§447.50 through 447.58."**

To be consistent with state policy, contracted providers (physicians, pharmacies, long term care facilities, etc.) of the health plans typically would be the entities contractually charged with collecting cost sharing amounts. The contracted providers presumably would have their contracted reimbursement levels from the health plans reduced by the value of the cost sharing, as the health plans would typically presume the providers are collecting cost sharing. The reality, however, is that only a portion of cost sharing will be collected, since the ability of the provider to deny service if the cost sharing is not paid by the member is often limited. It is possible that the provider may be able to negotiate a reimbursement rate with the health plan that essentially reflects the value of the portion of the copayments not collectible. If nothing was truly collectible and the provider did not suffer the loss, overall health plan costs could remain the same if the provider was vital to the health plan's network. Two directionally different assumption adjustments get the capitation rate to the same place—the matching of payment with risk.

The August 2005 practice note states: "When determining the appropriate adjustment for copayment amounts, an actuary considers an appropriate adjustment for a collection percentage associated with the copayment amounts."

Specific citation references of federal laws, rules, or regulations are always helpful reminders. Placement of the references cited in these questions within the revised CMS checklist would be appreciated.

11) **A.A. 3.10. Medical cost/Trend Inflation—This section references "price increases not accounted for in inflation" which applies if price increases are legislated by the Legislature. We have noted in several rate books that actuaries are incorporating "payment increases" that result from mandated FFS supplemental payments or broad-based provider taxes into the managed care rates as an adjustment. What**

advice have the actuaries given to states that want to make sure that these additional funds that they are unable to "return" to the providers under FFS payments get to the providers through MCO payments? How do they believe these costs should be reflected in the rate-setting process?

As previously mentioned, the Code of Professional Conduct calls for actuaries to comply with all federal and state laws, rules, and regulations. If an FFS fee schedule increase has been enacted and received any CMS-required approval, one assumption may be that the landscape for provider contracting has changed and that a similar (or potentially lower) increase for the same managed care service category also may be appropriate. Supply and demand in managed care contracting can be affected by state fee schedule shifts. The state typically does not know what the health plan is paying its providers, however, and hence the analysis around a "need" for an increase is further complicated. Availability of health plan payment information would help address these concerns. As always, access to care standards need to be considered when determining contracting reimbursement obligations.

"Pass-through" amounts are appearing in many states since the provider tax law was rescinded. If the health plans are responsible for paying higher fees, bonuses or extra payments to providers due to these arrangements, the amounts should be reflected in the capitation rates. State-mandated retroactive provider fee schedule adjustments that health plans are responsible for paying should be recognized in retroactive rates or settlements. This ties in with Question 5 and is a good example of why retroactive rate increases should be made.

Actuaries are not often involved in the funding component of the provider-increase equation. To the extent they are involved (in cases in which there might be a desire for confirmation of actuarial soundness, for example), the actuary typically would advise to make sure the state was comfortable with or had received formal or informal assurances of compliance with all CMS uniformity, broad-based, hold-harmless, and any other applicable provisions. Once new provider rates had been determined, the actuary for the state would not be involved with how the health plan(s) distributed funds to their providers. States could include language in health plan contracts requiring increases in provider payments tied to mandated FFS increases. The contract also could include how certain funds (for children's hospitals, for example) were included in the rate setting process, with the certification documentation and/or exhibits explicitly detailing the dollar or percentage amounts.

Adjustments such as these usually would be handled as any other program change within the body of the normal rate-development process. Depending upon the nature of the effort and the risk, the administrative and underwriting profit/risk/contingency load percentages could be affected.

12) **AA.2.6. Risk Corridors—The provision indicates that a payout under a risk corridor would not be actuarially sound to the extent that it exceeds the amount Medicaid would have paid on a fee for service basis. This is problematic as we do**

not rely on FFS expenditures as a benchmark in risk contracts any longer and as such states often are not running these claims through an MMIS enabling a FFS upper payment limit to be calculated. We only require a FFS UPL calculation to be performed on non-risk contracts. It does not seem worth the labor that is involved to perform such a UPL demonstration solely for a risk corridor payout. However, we do need to oversee such payouts to prevent abuse and to avoid creating a loophole that would one to circumvent actuarial soundness. What might be the best way to oversee risk corridors?

The checklist goes on to discuss that CMS and a state may agree in advance on payment limits to be applied to risk corridors such that CMS would share risk in losses, but only up to a predetermined maximum. We don't have any parameters for such an agreement and are in interested in what factors we should consider when arriving at such a negotiated payment limitation.

All payments under the risk contract are to be actuarially sound. The actuary therefore should be certifying that the risk corridor arrangement is in his or her view actuarially sound. All parties (the state, its health plans, and CMS) desire funding predictability. The state budget does not want temporary surpluses from too-low capitation rates, which surplus then would have to be returned in part or in whole only months later due to a risk corridor provision. As a result, there are several up-front perspectives that should lead to the development and contracting agreement of the correct relationship between underlying capitation rates and the risk corridor. Oversight, of course, is desirable. One approach is tracking payments/recoveries under the risk corridor over time if it is not a new program. This could help detect any unintended bias.

The smaller entity(ies) often would be the one(s) requesting a limit on its (their) exposure to losses under a cost-sharing arrangement. CMS obviously would be the larger entity in all instances. If there is a history of additional CMS payments under the arrangement and all other things being equal, CMS may look to impose a cap of a multiple factor of the average annual historical payment, such as 1.25 or 1.5, etc. This would be only one example of a large number of possibilities. Any amount limitation on CMS' potential liability obviously shifts this potential risk to the state and its contracted health plans. It is our understanding that historically risk-corridor payments in excess of 25 percent of the capitation payments were used as the "trigger" level, resulting in a request to the state to price encounters at the FFS fee schedule.

13) **Administrative costs in rates—If within a capitation rate there are facility overhead and operating costs is this allowable in light of the SMD letter regarding Administrative Cost, dated December 20, 1994 that says facility overhead and operating costs are not allowable? Does that only pertain to admin costs claimed at 50% by the States or would it also apply to costs within rates. What is the range of "acceptable" for the administration component of each rate. We generally operate with a rule of thumb of 15%; however, is this generally accepted?**

We do not believe the referenced State Medicaid Director letter discussion on facility overhead and operating costs is applicable to at-risk Medicaid managed care health plans. We believe instead that it is applicable to states claiming for administrative match on the CMS-64.10 and DHHS cost allocation plans.

It is our understanding that the 15 percent rule of thumb was derived from 1993 Agency for Healthcare Research and Quality (AHRQ) research on the managed care industry. Ranges of acceptable values for Medicaid health plan administration are difficult to generalize. Multiple questions abound. For example: Are capitation rates set on a plan-specific, county average, regional, state-wide, or some combination basis? Are there any state-mandated assessments or taxes counted as part of administration? There should be an actuarial basis provided for the administration component development that includes an understanding of the state requirements of the health plan (and any changes to those requirements) to administer the program.

From the August 2005 practice note: "In determining an appropriate level of an administrative cost allowance, the rate-setting actuary may want to consider the following items: Overall size across all lines of business; Lines of business covered by the capitation; Age of the health plan or years of participation in Medicaid; Organizational structure; Demographic mix of enrollees; Marketing expenditures; Claims processing expenditures; Medical management expenditures; Staff overhead expenses; Member services; and Interpreter services."

Historical and benchmark administrative costs of the health plan(s) (per member per month and percent of capitation) provide valuable information. In addition, there is the question as to whether the health plan globally subcapitates its risk, meaning claims and an undetermined portion of administration and assumed profit are passed on to a third party. Global subcapitation expenses often are included in medical expenses, with no segmentation breaks into these incremental administration or profit components.

Does the rating structure use a fixed-and-variable approach to administration load by rating category, or use a flat percentage across all rating categories? Either approach is reasonable, and will aggregate to the same projected percentage and dollars. But fixed and variable will generate a higher administration percentage for lower claim cost aid categories (a child category, for example) and a lower administration percentage for higher claim cost aid categories (long-term care, for example). At a service category level, pharmacy claims typically process less expensively.

Performance incentives/bonuses usually are separately developed amounts/rates outside of administration. Penalties/withholds are performance measures. They do place health plan administration at risk. The level (and likelihood of quality metric achievement) of any withhold in comparison to the overall administration load and capitation rate should be considered.

Question 13 did not specify whether the underwriting profit/risk/contingency/contribution to surplus load is rolled into administration. In the determination of an appropriate level

of a profit and risk allowance, the rate setting actuary may want to consider the following items: contingency margin; contribution to surplus; investment rate of return; and profit margin. Any applicable solvency/risk-based capital requirements and profit guidelines from the state insurance department should be evaluated.

To provide further background for the underwriting profit/risk/contingency/contribution to surplus load, some actuaries believe that while allowing for the build up of necessary reserves is vital, health plans with large reserves may be able to withstand a few years of no or low assumed profits. Other actuaries would disagree strongly, pointing to the importance of each contract year's rates standing on its own. Some actuaries also would take the traditional approach that the rate methodology should not have a bias towards either for-profit or non-profit health plans. Other actuaries strongly believe there should be a differentiation.

14) **State Assurances and Certification—If we review the actuarial certification as a stand-alone document, it is difficult to indicate State compliance with those sections that require State assurance or State documentation. For example, as shown in Table 1, the rate-setting documentation is an exclusive source for State assurance or documentation in several steps.**

Table 1. Rate-setting sole source

AA	Subject
1.6	Provider Payment Limit
2.0	State Plan Services
2.1	Medicaid Eligible Individuals
3.1	Benefit Differences
3.2	Administrative Cost
3.3	Special Population Adjustment
3.12	Utilization & Cost Assumptions
3.13	Post-eligibility Treatment of Income

Part of the challenge is to bridge the regulatory divide between State assurance documentation and the actuarial certification document. One possible solution may be to require the State to prepare an assurance letter/document on appropriateness and submit the certification as an attachment? Do you have any opinions on this approach?

42 CFR 438.6(c)(4) requires the two items: an actuarial certification and state assurance documentation. In many instances, the state documentation has been prepared by the actuary. The actuary often provides a crosswalk showing the CMS checklist steps and the corresponding report section(s) covering the steps and/or other comments. The suggestion to require states to prepare an assurance letter/document on those contract checklist or rate-setting checklist sections that require assurance or documentation seems to make sense. To the extent this material is not provided elsewhere, gathering and reporting it would require additional state resources. Perhaps this approach also could

result in a slightly shorter certification letter, which, as proposed, still would serve as an attachment.

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We hope that our responses to the CMS questions and comments, both on the two conference calls as well as within this document, are helpful to you and your staff as you move forward with improvements to the process of monitoring Medicaid managed care capitation rate development. We look forward to providing you with any additional assistance you may request. If you have any questions regarding this letter, please contact Tim Mahony, the Academy's State Health Policy Analyst, at mahony@actuary.org or 202.785.7880.

Sincerely yours,

Michael E. Nordstrom, ASA, MAAA
Chairperson, Medicaid Work Group
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Cc: Academy Medicaid Work Group