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July 27, 2015

Ms. Nicole Kaufman
Technical Director – Medicaid Managed Care Policy
Medicaid Managed Care Operations
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2390-P
Baltimore, MD 21244

Re: Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability; Proposed Rules

Dear Ms. Kaufman:

On behalf of the American Academy of Actuaries’¹ Medicaid Subcommittee, I am submitting comments on the proposed rules regarding the Medicaid and CHIP programs.

Summary of the Proposed Rules

Via the June 1, 2015, *Federal Register*, “This proposed rule would modernize the Medicaid managed care regulations to reflect changes in the usage of managed care delivery systems. The proposed rule would align the rules governing Medicaid managed care with those of other major sources of coverage, including coverage through Qualified Health Plans and Medicare Advantage plans; implement statutory provisions; strengthen actuarial soundness payment provisions to promote the accountability of Medicaid managed care program rates; and promote the quality of care and strengthen efforts to reform delivery systems that serve Medicaid and CHIP beneficiaries. It would also ensure appropriate beneficiary protections and enhance policies related to program integrity. This proposed rule would also require states to establish comprehensive quality strategies for their Medicaid and CHIP programs regardless of how services are provided to beneficiaries. This proposed rule would also implement provisions of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and addresses third party liability for trauma codes.”

The document (including preamble) includes significant breadth and depth. With over 230 references to variations of “actuary/actuarial” and another 250+ references to “capitated/capitation,” the subcommittee limited the material on which it chose to comment. Hence most comments or questions have been grouped under “Rate-setting” (Sections 438.2 through 438.7) and “Medical Loss Ratio (MLR)” (Section 438.8).

¹ The American Academy of Actuaries is an 18,500+ member professional association whose mission is to serve the public and 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.

References

While the subcommittee members relied upon their collective expertise, and a combined decades of experience in Medicaid managed care actuarial rate-setting and other actuarial issues, two source documents are regularly referenced in our comments and questions below, and are listed here:

- Actuarial Standard of Practice (ASOP) No. 49 “Medicaid Managed Care Capitation Rate Development and Certification” http://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf
- CMS’ Rate-setting Checklist “Documentation Requirements for Actuarially Sound Capitation Rates Effective Date: November 15, 2014”

General/Miscellaneous Comments

1. The subcommittee supports any necessary additional capitation rate development transparency and documentation requirements.² With the CMS-2390-P NPRM, CMS has made multiple positive policy advances in this regard.

We request that CMS consults with states and their health plan partners to consider the amount of lead time necessary for state programs and actuaries to implement the changes necessary to comply with the final new rules. The rate-setting process generally begins approximately 12 months prior to the contract effective date, and material changes would lengthen that timeframe.

2. The total associated cost and burden to states and their staff are, however, of significant concern. The details of the proposed rule and associated sub-regulatory requirements, along with relatively recent history surrounding Medicaid managed care implementation of the Affordable Care Act (ACA) Section 1202 (increased payments for primary care) and Section 9010 (health insurance providers fee) rate-setting provisions, suggest that a considerable amount of additional staff resources, time, and money will be needed in order to comply as written. This cost and burden is not consistent with 2015, and beyond, state budget realities, and the additional funding required should be addressed.
3. The subcommittee’s comments reflect a recognition that health plan employed actuaries and state employed actuaries have different perspectives (e.g., the appropriateness of capitation rate ranges). Each group or individual brings valuable experience, expertise, and perspective to any discussion, and CMS should carefully consider each perspective as it finalizes Medicaid managed care rules and regulations.

Key Actuarial Issues

Although the detailed comments and questions on the proposed rule can be found below, we have summarized key actuarial issues below. The selection of these key issues is dependent on expected CMS responses to the large number of comments and questions not reflected in this summary. Should some of CMS’ responses differ from expected, those items would join the bulleted items highlighted here. Key actuarial issues for CMS and actuaries are as follows:

²http://www.actuary.org/files/American_Academy_of_Actuaries_Letter_on_Rate_Setting_Checklist_to_CMS.4.pdf
[/American_Academy_of_Actuaries_Letter_on_Rate_Setting_Checklist_to_CMS.4.pdf](http://www.actuary.org/files/American_Academy_of_Actuaries_Letter_on_Rate_Setting_Checklist_to_CMS.4.pdf)

- CMS' decision concerning rate range certification usage;
- Appropriate rate-setting flexibility in the development of health plan administrative cost loads;
- 85 percent minimum MLR is likely too high for some low-cost rate cells;
- MLR a consideration, but not a formal rating variable, within typical actuarially sound capitation rate development;
- Prospective claim cost trend development should not be limited in data or information sources utilized;
- Continued allowance of rate update approaches;
- Formal review of a health plan's operating needs should not be part of a capitation rate withhold analysis;
- Reliance upon state and health plan analyses and assurances re assessment of availability of services, adequacy of capacity, services, and provider network; and
- Next generation rate-setting with payment by state to health plan for value instead of volume (as recorded by encounter data) should be addressed.

Rate-setting

Section 438.2 Definitions

1. Please confirm capitation payment includes those items in ASOP No. 49 Sections 2.3 and 3.2.2 and the CMS Rate-setting Checklist Section AA.4.
2. Please confirm case payments are included and allowable within the current definition of rate cells. A commonly used case payment in Medicaid managed care is the maternity delivery payment, which is triggered by evidence of a valid encounter record submitted by a contracted health plan. This case payment is generally in addition to a per member per month (PMPM) capitation payment for a covered member. Additionally, several states use "add-on" rate cells for specific populations or benefits that require special attention. For example, a state may pay the medical acute benefit as one rate cell and the long-term services and supports as an add-on rate cell.

Section 438.3 Standard contract requirements

1. Section 438.3(c) requires that only costs for the provision of state plan services be included in the capitation rates. Please confirm the inclusion of cost-effective "in lieu of services" continues to be allowed. This would also be consistent with ASOP No. 49, Section 3.25 and the CMS Rate-setting Checklist Attachment 3.
2. In Section 438.3(e) please confirm that, consistent within current practice, "in lieu of services" should be included. See ASOP No. 49 Section 3.25 and the CMS Rate-setting Checklist Attachment 3.
3. In Sections 438.3(m) and 457.1201(j) if the audited financial reports must be for Medicaid and/or CHIP experience only, and are not currently produced, this may increase reporting costs materially for some entities. There should be options for alternative CEO/CFO assured/certified reports or for those done on a statutory accounting basis.

Section 438.4 Actuarial soundness

1. Section 438.4(b)(1) requires that any proposed differences among capitation rates according to covered populations must not be based on the federal financial participation percentage associated with the covered population. We request clarification be added to indicate that capitation rates may likely vary by population for numerous reasons, but that federal financial participation percentage is not an allowable justification.

We propose language be inserted such as the following: “Any proposed differences among capitation rates according to covered populations must be based on valid rating factors and not be based on the federal financial participation percentage associated with the covered populations.”

2. Section 438.4(b)(4) requires that capitation rates be specific to payments for each rate cell, effectively eliminating the ability of actuaries to certify a rate range. While we understand the concerns associated with rate ranges, there are several benefits in rate-setting of allowing appropriate rate ranges. Because capitation rates are developed on a prospective basis, typically encompassing multiple participating health plans in one program, ranges for specific assumptions such as claim cost trends, administration, and underwriting gain allow the rate-setting process to better capture the various contracting, utilization management, administrative and for-profit status of the participating health plans, as opposed to a single point estimate.

Additionally, we believe there may be unintended consequences of removing rate ranges altogether. For example, for the health insurance providers fee (HIPF) some states certify a rate range with the lower bound selected for health plans not subject to the fee and the upper bound sufficiently higher to include the largest impact of the HIPF. We also believe that competitive bidding situations could become more difficult or less flexible without rate ranges because the bids are developed by each health plan using a specific set of assumptions. The state’s actuary may have difficulty certifying a specific point estimate that was based on another actuary’s assumptions.

Rate ranges also can lessen the administrative burden on the state and CMS in recertifying and submitting rates for approval if minor changes occur to the program after the rate development work and certification is completed. It is our understanding that many state-employed actuaries prefer flexibility of rate ranges be permitted to continue, with discussions about options for potentially limiting the width of ranges (e.g., no more than +/-5 percent around a mid-point rate, exclusive of any range for HIPF) or applying ranges only to specific rating assumptions. At the same time, many health plan-employed actuaries do not believe rate ranges are appropriate, with the exception of those circumstances within the preceding paragraph.

3. Section 438.4(b)(4) requires that capitation rates be specific to payments for each rate cell. We are uncertain how administrative costs may be affected with respect to this requirement. We propose including more explicit clarification that the development of administration costs are not required to be completed at the rate cell level of detail. Rather, we propose that the language specifies that developing the administration costs across the program is a reasonable and appropriate way to incorporate these costs as a part of the rate development process.

There is not a generally accepted standard for a health plan or state actuary to determine administration costs by rate cell at the age/gender detail level, or even the Temporary Assistance for Needy Families (TANF), Children’s Health Insurance Program (CHIP), Supplemental

Security Income (SSI) level when these are under one combined contract. This concept was discussed during the ASOP No. 49 development process. Specifically, the developers of the ASOP noted:

Comment: Several commentators believed that the ASOP would require separate administrative loads be developed for each rate cell and recommended not requiring this.

Response: The reviewers believe that the ASOP allows the actuary to use his or her judgment about whether or not a single administrative load, margin, or cost of capital assumption is appropriate for all rate cells.

4. Section 438.4(b)(8) requires that capitation rates be set such that the health plan would reasonably achieve a minimum 85 percent MLR, adjusted for credibility. The 85 percent minimum may not be appropriate (too high) for some Medicaid or CHIP rates. One example are programs that are 100 percent administrative costs, such as case management services for new mothers, or rates for children, with or without substantial service carve-outs, which produce very low capitation rates. Hence, a minimum MLR target should be in aggregate, not rate cell specific.

This section states that capitation rates can be set to assume MLRs greater than 85 percent “as long as the capitation rates are adequate for necessary and reasonable administration costs.” This wording could lead to the assumption that the only non-benefit component required in the rate to meet this section of the regulation is administrative costs and that it excludes other non-benefit components of the rate development including taxes, licensing and regulatory fees, contribution to reserves, profit margin, cost of capital, and other components. We suggest revising the section to say, “as long as the capitation rates include appropriate and reasonable non-benefit costs.” This mirrors the wording in Section 438.5(e) that defines these components of the rates.

Here, and within Section 438.5(b)(5), the proposed rule implies that MLR tracking/reconciliation and inclusion as a consideration in rate-setting will ensure on-going actuarial soundness. However, in ASOP No. 49, Section 2.1 does not include as part of the definition of Medicaid capitation rate actuarial soundness financial results/MLRs of individual rate cells or health plans. MLR is a financial measure of an individual health plan’s operating results in the program, but it should not be perceived as requiring actuaries to “target” or “correct” rates if individual rate cells or health plans are not meeting the minimum MLR (or a maximum MLR).

Section 438.5 Rate development standards

1. With respect to the “budget neutral” definition in Section 438.5(a), to be consistent with the prospective nature of the rate development process, we propose including the following language “...and does not create an expected net aggregate gain or loss across all payments.”
2. With respect to the “risk adjustment” definition in Section 438.5(a), to be consistent with ASOP No. 45, which specifically covers the topic of risk adjustment, we propose including the following language: “Risk adjustment is a methodology to account for the health status of enrollees via relative risk factors when predicting...”
3. Section 438.5(b) includes six “steps.” The steps generally contain the components and considerations of capitation rate-setting, but the order in which they are presented may not align with all the variations that exist today. For example, Step 4 (adjustments for benefit, program and other changes) may be performed before trend. Please clarify within the regulation if CMS

anticipates requiring a specific order of adjustments or if states and actuaries will have flexibility with the capitation rate-setting order of adjustments.

4. In Sections 438.5(b)(1) and (2) and 438.7(b)(2) on base data and trend, the proposed language identifies both utilization and cost/price data in these sections. Some programs currently only have financial PMPM data available, which combines the utilization and cost/price data. Please confirm these types of PMPM data sets are still a viable option for rate development.
5. In Sections 438.5(b)(2) and 438.5(d) on trend, while we agree that actual experience from the Medicaid, or a similar, population, should be the primary source of trend data and information, generally accepted actuarial practices and principles do not limit or restrict the data and information sources used in trend development. Prospective trends may, and often do, differ materially from historical experience trends, whether or not it is from the Medicaid population or a similar population. Examples include the acceleration of high-priced Breakthrough Therapy Designation drugs and drugs losing patent protection, which shifts drug utilization from higher-priced brand-name labels to lower-priced generics. We propose including clarifying language to allow other appropriate and relevant data, other information sources, and professional judgment to aid in the development of prospective trends.
6. Sections 438.5(b)(3) and 438.5(e) discuss the requirements for the non-benefit costs within the capitation rates. The use of the word “or” in the section of the sentence, “... cost of capital; or other operational costs” leads a reader to interpret that the listed expenses are not all part of rate setting. Please see ASOP No. 49 Section 3.2.12. To ensure appropriate non-benefit expenses are included in the rates, we suggest that “or” be replaced with “and” in this section of the sentence.
7. In Sections 438.5(b)(4) and 438.7(b)(4), please confirm that all adjustments including, but not limited to, those in ASOP No. 49 and the CMS Ratesetting Checklist continue to be valid under the proposed rule as part of generally accepted actuarial principles and practices.
8. Section 438.5(b)(5) requires that a health plan’s past MLRs be taken into account in the development of the capitation rates. We request additional guidance with respect to how this requirement may be satisfied. Common practice is to review the historical and emerging financial experience of both the individual health plan and for the program as a whole, but rarely, if ever, is a specific adjustment made in the capitation rate-setting process to adjust for the MLR observed or emerging. Historical loss ratio data will not reflect more recent changes to programs and capitation rates that would bring expected experience in line with capitation rate development assumptions.
9. Section 438.5(b)(6) discusses the requirements for risk adjustment within the capitation rates. The preamble makes it clear that Step 6 of the rate-setting process – the risk adjustment process – is only applicable if the state has decided to risk adjust the capitation rates. The regulation does not make this distinction, but we believe it should. We suggest modifying the language to indicate that Step 6 is only applicable when the state is choosing to risk adjust the rates, but can be ignored if the state is not risk adjusting the rates.
10. Section 438.5(c) discusses the base data selected for the development of the capitation rates. We recommend that the data sources section be expanded to include unaudited health plan restated experience reports. These are currently used as a data source and are a good source of information as they restate the premium and the claims expense to the correct time periods. They also match the state’s rate fiscal period, which might not align with the National Association of Insurance Commissioners (NAIC) financial filings that are set on a calendar quarter and year basis.

However, these reports typically are not officially audited. There may be ways to ensure data validation through other means (such as a certification by the health plan CEO/CFO) than via an official accounting audit.

11. Section 438.5(c)(1) requires that states provide, among other items, all of the validated encounter data for at least the most recent three-year period. There are situations in which this is not feasible. For example, a state with a small voluntary managed care program may not have the resources to require submission and validation of encounter data for the program. The gathering and transmission of three years of data may also be costly. We propose changing the language to include “(as appropriate)” following “States must provide all the validated encounter data.”
12. In Section 438.5(c)(1), for programs of credible size, generally accepted actuarial principles and practices typically would allow for use of only one year of data. (Two years also may be regularly used.) If so, any time periods greater than that may add prohibitive cost. Rather than a mandate, the base data should be determined via actuarial judgment, consistent with ASOP No. 49, in consultation with the state.
13. Section 438.5(c)(2) requires the use of the most appropriate data. We request clarification of whether CMS intends that capitation rates must be based on three years of data. For example, would it be permissible to base the capitation rates on one year (or two, per above) of data, so long as the selected year is within the three-year window of recent and completed years?
14. In Section 438.5(c)(2), please confirm that rate updates, in ASOP No. 49 Section 3.2.3 and the CMS Ratesetting Checklist introduction, are still an approvable rate-setting option.
15. Section 438.5(c)(3) requires states to request an exception for use of data outside of the requirements in 438.5(c)(2). We request that the exception and explanation can be contained within the actuarial certification documentation if the actuary is the originator of the exception request. We believe it will often be the opinion and request of the actuary to modify the base data used in the capitation rate development process.
16. In Section 438.5(e), consistent with the definition of actuarial soundness, non-benefit components of the rate should be reasonable, appropriate and attainable.
17. Section 438.5(f) discusses the requirements for the base data adjustments within the capitation rates. CMS requested comment on its decision to not provide an explicit list of permissible adjustments. We agree with this decision as the list could never be comprehensive given the dynamic nature of Medicaid and CHIP programs. However, the adjustments should include, but not be limited to, those referenced in ASOP No. 49 and the CMS Rate-setting Checklist.

Section 438.6 Special contract provisions related to payment

1. Section 438.6(b) discusses the requirement for, among other items, capitation withholds in the health plan contract. Specifically, the actuary is to include only the portion of the withhold that is reasonably expected to be earned by the health plan. We believe the following provide a general process for the actuary to follow in making this determination:
 - Review the language and criteria for earning back the withhold for prior contract years.
 - Review the language and criteria for earning back the withhold for the rate period.
 - Assess the differences between prior years and the rate period.
 - Review the achieved earn back by the health plans in prior years.

- Based on the above, extrapolate and use actuarial judgment to determine the achievable amount.

Alternative cost effective approaches such as health plan attestation related to the appropriateness of the withhold amount(s) may be considered.

2. Section 438.6(b)(3) requires that the total amount of a withhold must be reasonable and take into consideration the health plan's financial operating needs accounting for the size and characteristics of the populations and the health plan's capital reserves or months of claims reserve. This requirement is too restrictive in that the certifying actuary is not ensuring solvency or opining on the appropriateness of the capitation rate for any single health plan. This requirement puts unintended and inappropriate responsibility on an actuary related to the financial condition of a health plan with which they are not related and responsible. We request that this portion of the requirement be removed to clarify the intended responsibility of the certifying actuary.
3. Section 438.6(b)(4) requires states to adjust the actuarially sound capitation rates to account for Graduate Medical Education (GME) payments made outside of the capitation rates. We request clarification of this requirement. In certain cases GME is included in the capitation payment and other times it is paid by the state directly. In the case of a state making this payment directly, often it is not in the capitation rate from the beginning; therefore, an adjustment would not appear necessary. Additionally, please clarify the intention of the requirement that the state must first establish the actuarially sound capitation rate prior to making adjustments for GME.
4. Section 438.6(c) includes provisions allowing states to require health plans to participate in innovative payment mechanisms, performance measures or delivery system reform. In certain situations a managed care organization (MCO), prepaid inpatient health plan (PIHP) or prepaid ambulatory health plan (PAHP) may be covered by two arrangements with the state, such as a capitated risk contract and an arrangement that shares savings with providers. Assumptions for claim cost trend and other pricing factors that are used to calculate risk sharing payments, capitation rates, and the like, should be consistent and updated considering actual experience. Savings should not be inappropriately double-counted under multiple arrangements.

Section 438.7 Rate certification submission

1. With respect to the non-benefit component of the rate in Section 438.7(b)(3), we propose language indicating the non-benefit component may be developed in as much detail as identified in the proposed rule, for example, or in a more aggregate way such that the total administrative and underwriting gain components are reasonable, appropriate and attainable whether developed at a detail line level or in a more aggregate fashion.
2. With respect to adjustments to the rate in Section 438.7(b)(4)(ii), absent a formal CMS definition of materiality, we propose language that materiality is determined by each certifying actuary and documented in the certification.
3. Section 438.7(b)(5) requires, among other items, that the capitation rate certification documentation contain significant detail with respect to the results of the risk adjustment calculation. Often, the risk adjustment calculation is performed following certification of the base rates and in certain cases occurs more frequently throughout the year covered by the capitation rate certification. Please clarify whether this is intended to require updated or amended capitation rate certifications when a risk adjustment is performed throughout the contract year. This would represent a significant change from current practice in that the rate certification is for the base capitation rates and the documentation of risk adjustment certifies that it is being applied on a budget neutral basis. Additional Section 438.7(b)(5) comments and questions:

- Sub-section E requires an assessment of the predictive value of the risk adjustment methodology compared to prior rating periods. For most programs, this will be additional administrative effort going forward. We believe this may be better addressed via reliance upon ASOP No. 45, which specifically covers the topic of risk adjustment, and the CMS Rate-setting Checklist AA.5.4 which indicates use of “generally accepted diagnosis groupers.”
 - Sub-section F requests identifying any concerns the actuary has with the risk adjustment process. Actuaries do not choose or develop the individual risk adjustment factors in many of the states in which capitation rates are set. The actual derivation, cost weights, etc. are typically considered proprietary by either an outside vendor or perhaps even a state. To include “concerns” from the certifying actuary that does not have that detailed knowledge about the risk adjustment process or a way to validate it without undue cost burden is a challenge to request. Perhaps include language that says, “Where the certifying actuary is responsible for the development of the risk adjustment process, provide any concerns the actuary has with the risk adjustment process.”
 - This concern about the actuary often not owning the risk adjustment process applies to almost all of the sub-sections here. Will it now be a requirement that the actuary include this as a part of the actuarial certification documentation even though risk adjustment can be calculated and applied to the certified base rates by the state or outside vendors?
4. In Section 438.7(c), within a developed actuarially sound capitation rate range, an almost infinite combination of values is possible for those independent variables creating the range. States utilize rate ranges for multiple reasons in paying different health plans different capitation rates. Mathematically solving for variable values to generate a specific rate is unnecessarily resource and cost intensive.

General

1. In describing capitation rates and payments, for example such as in Sections 438.3(c) or 438.4(b)(8), for the at-risk programs throughout the NPRM, for consistency with the definition of actuarial soundness in 438.4(a), we suggest substituting “reasonable, appropriate and attainable” with “appropriate.”
2. Please clarify if the proposed rule requires actuaries to engage in the assessment of availability of services, assurances of adequate capacity and services, provider network adequacy, etc. (Sections 438.206, 438.207, 438.68 and 438.208). While these are important service requirements of the health plans, they generally are built in as part of the contract provisions between the state and the MCOs, PIHPs and PAHPs. In practice, actuaries rely on state and health plan information that these requirements, among many other contract provisions, will be fulfilled when developing the capitation rates. While a few actuaries may have developed expertise and related experience in some or all of these areas, for the vast majority of actuaries the topics are outside of their professional qualifications. Actuaries need to be able to rely upon analyses and assurances for these topics by qualified state, and health plan, professional staff.

Finally, the capitation rate development provisions within the NPRM do not appear to support “next generation” triple aim delivery system reform efforts by states, in which substantial portions (perhaps well above 5 percent) of payments *by the state* to quality, cost efficient and effective MCOs, ACOs, PIHPs, and PAHPs should be for providing better care (quality and patient satisfaction) and improved population health. The flexibility within rate-setting for a state to pay quality, cost efficient, and effective health plans for value or outcomes, instead of volume (as recorded by encounter data), does not appear to

have a clear path, and should be addressed. For example, what if the state requires 20 percent of payments for “quality/value?” The proposed rule and other CMS guidance provides considerable material on how health plans can work with direct providers of care to reimburse around quality/value. However, there is not much flexibility on how states would pay health plans for that. So if health plans (with their providers) provide quality/value and individuals are healthy, then there isn’t a claim/encounter to be generated. And if there isn’t a claim/encounter, there would be nothing in the base data for rate-setting. As a result, the health plan could essentially provide quality/value and still be penalized. CMS needs to provide information on ways to include quality/value in the base data.

Medical Loss Ratio (MLR)

1. Section 438.8(b) describes the base credibility factors CMS will publish annually. For individual, small group, and large group health insurance, full credibility for MLR calculation purposes was determined to be 75,000 life-years, or 900,000 member-months. For Medicare Advantage full credibility for MLR calculation purposes was determined to be 180,000 member-months, with 360,000 member-months needed for stand-alone Part D coverage. Will CMS produce a credibility table that is used for all Medicaid contracts, or will separate standards apply to long-term care compared to acute care? For the nursing facility eligible population, the variability of claims from person to person is less than that for acute care, so a managed long term care population could be fully credible with fewer persons compared to an acute care population. A credibility calculation performed on a blend of acute care and long-term care claims data could produce results that would be inappropriate for a population that consisted only of acute care risks.
2. Sections 438.8(e) and (f) do not explicitly mention pass-through amounts that are not at risk, such as Upper Payment Limit (UPL) payments to providers or GME payments. Other examples could include specific high cost drugs. If a state does not treat such payments as premium, then the amounts should not be included in the MLR calculation numerator or denominator. If, however, a state treats such payments as premium, a reasonable treatment for the MLR calculation would be to initially include such amounts in premium but also then to deduct them from the denominator in a treatment similar to taxes, with the pass-through amounts included in incurred claims and then deducted from the numerator. If pass-through amounts were included as incurred claims and as premiums, then the ratio reported by the MLR calculation would be higher than intended. Exclusion of pass-through amounts from incurred claims while including them in the premium would produce a ratio that would be lower than intended. Please clarify the treatment of pass-through amounts in the MLR calculation.
3. Section 438.8(e)(2) provides details on incurred claims used in the MLR calculation. The details include some items that appear to be duplicative and also appear to omit items that should be included. Please consider indicating that all items that are incorporated in the definition of claims as reported in the instructions to the NAIC Health Annual Statement are considered incurred claims, or provide a list that parallels the treatment of incurred claims in the statutory statement in completeness and detail. Then list any exceptions. Amounts used should be only those that are incurred in the reporting period – both those paid through the runout period plus accruals for amounts not paid as of the end of the runout period. The following specific items (numbers 4-10) are noted below.
4. Section 438.8(e)(2)(i)(A) provides that incurred claims include “Direct claims paid ... to providers (including under capitated contracts with network providers).” Does any portion of the capitation payment need to be considered non-claim expense for administrative services? While 100 percent of a capitation payment made to an individual primary care physician is clearly claims, what about a global sub-capitation paid to another health plan or a hospital-based care

delivery system which covers costs for all medical services, as well as costs for claim adjudication for those services? Should this section and 438.8(e)(3) be expanded to include providers beyond health care professionals, so that the globally sub-capitated health plan or the hospital-based care delivery system would be included?

5. Section 438.8(e)(2)(i)(B) relates to “Unpaid claims reserves for the MLR reporting year, including claims reported in process of adjustment.” This item should be the estimated unpaid claims *liability*, which includes claims in process of adjustment plus claims incurred but not reported (language used in (F)), as well as amounts withheld from paid claims and capitations. The distinction between a claim *liability* and a claim *reserve* is that an estimate of a liability refers to an event that has already happened, such as medical services rendered during the reporting period, but an estimate of a claim reserve involves future contingent events (such as in item (H)). In determining the MLR used in premium rebates, states will likely choose to require a number of months of actual runout beyond the end of the reporting year, so that the estimate of unpaid claims will be small. States also may review the calculation of the estimate of unpaid claims.
6. Section 438.8(e)(2)(i)(C) provides that incurred claims include, “Withholds from payments made to network providers.” NAIC statutory accounting instructions provide that “for arrangements involving amounts withheld, the claim payments should be recorded net of the withhold, and the unpaid withholds should be held as an additional liability until paid or formally retained.” We recommend that any MLR-based premium rebate calculations not be finalized until all withhold calculations for the reporting period are finalized, so that the withhold amounts are either paid or formally retained.
7. Section 438.8(e)(2)(i)(D) provides that incurred claims include, “Claims that are recoverable for anticipated coordination of benefits.” The language here could be interpreted that the claims recoverable for anticipated coordination of benefits (COB) are to be added to the other listed items. Actually, such recoverable amounts would be a negative component of incurred claims, after having initially been a positive claim. To the extent that COB recoveries are run through the claim triangle, the calculated estimate of the unpaid claims liability would use data that includes the negative payments that represent the COB recoveries, so the unpaid claims liability estimate would implicitly include the effect of COB recoveries. COB collections accounted for outside the claim triangle data would need separate recognition.
8. Section 438.8(e)(2)(i)(E) provides that incurred claims include “Claims payment recoveries received as a result of subrogation.” The language here could be interpreted that the claims subrogation recoveries are to be added to the other listed items. Actually, such recoveries would be a negative component of incurred claims after having initially been a positive claim. The language here also could be interpreted that the claims subrogation recoveries are to be included only to the extent that they are actually collected, without accruals for subrogation expected to be collected in the future. To the extent that subrogation recoveries are run through the claim triangle, the calculated estimate of the unpaid claims liability would use data that includes the negative payments that represent the subrogation recoveries, so the unpaid claims liability estimate would implicitly include the effect of subrogation recoveries. Subrogation often is a lengthy process, so amounts actually recovered in the months of runout used for the MLR calculation could understate the ultimate subrogation recoveries. Also, subrogation recoveries accounted for outside the claim triangle data would need separate recognition.
9. Section 438.8(e)(2)(i)(G) provides that incurred claims include, “Changes in other claims-related reserves.” This language includes the reserve for future contingent benefits, which provides for

the extension of benefits after termination of the policy. Such extensions are rarely, if ever, seen for Medicaid. They would involve a health plan being required under the contract to pay for services for a person incurred in a period for which the MCO received no capitation for that person. Claim reserves (as contrasted with estimates of claims liabilities) are shown on the NAIC statutory statement on the Underwriting and Investment Exhibit Part 2D – Aggregate Reserve for Accident and Health Contracts Only. Line 9 is the present value of amounts not yet due on claims, which is for disability income, not payment of medical expense. Line 10 is the reserve for future contingent benefits. Line 11 is for other claims reserves. Claims *reserves* are reported on Line 7 of the Page 3 balance sheet. The following items should not be permitted as claims-related reserves – policy reserves (such as contract reserves or premium deficiency reserves, which appear on Line 5 of the Page 3 balance sheet) or unpaid claims adjustment expenses, an administrative expense liability, which appear on Line 3 of the balance sheet.

10. Section 438.8(e)(2)(i)(H) provides that incurred claims include, “Reserves for contingent benefits and the medical claim portion of lawsuits” This language may be partially duplicative with that of (G), since contingent benefits reserves are claims-related reserves. 438.8(e)(2)(H) includes the medical claim portion of lawsuits in the numerator.
11. Section 438.8(e)(2)(ii)(A) provides that items to be deducted from incurred claims include, “Overpayment recoveries received from health care professionals.” This should not be limited to health care professionals; all providers should be included. This also should include the amount of recoveries in a receivable status. When overpayments are recovered, those attributable to particular claims may result in an adjustment to amounts that appear in the claim triangle. Others may need to be accounted for separately.
12. Section 438.8(e)(2)(ii)(B) provides that items to be deducted from incurred claims include, “Prescription drug rebates received.” We recommend that you change this wording to reflect rebates received and accrued.

In addition to pharmaceutical rebates receivable and claim overpayment receivables, the NAIC Annual Statement also includes the following categories of health care receivables: Loans and advances to providers, capitation arrangement receivables, risk sharing receivables, and other health care receivables. Loans and advances to providers may be payments that have been made to them that will be discharged as claims are paid, so that the incurred claims that they represent are accounted for in the estimate of the unpaid claim liability. The other items should be accounted for in the MLR as adjustments to incurred claims.

Note that health care receivables are classified as either admitted or non-admitted assets. A health care receivable may be non-admitted if it is uncollected more than 90 days after the provider has been invoiced, although undisputed amounts receivable from the government for programs such as Medicaid can be classified as admitted even beyond 90 days. In the NAIC annual statement, both admitted and non-admitted health care receivables are used in the determination of incurred claims. Please clarify how health care receivables will be treated in the MLR calculation. Are non-admitted receivables included?

13. Section 438.8(e)(2)(ii)(C) provides that the incurred claims in the numerator are to be reduced by “State subsidies based on a stop-loss payment methodology.” This is clearly needed because the capitation rates paid by the state in such situations recognize claims only up to a certain level. Some states require health plans to purchase stop loss reinsurance, but the proposed rule requires premiums used in the MLR calculation to be direct premiums written, not premiums net of reinsurance. Health plans could see these treatments as inconsistent with one another. One way to

reconcile this would be to permit premiums used in the denominator to be reduced by stop loss reinsurance premiums ceded under the following circumstances: (1) the state contract with the health plan requires the health plan to purchase stop loss coverage, (2) the stop loss reinsurer is financially independent of the direct writing health plan, (3) the stop loss attachment point is not lower than the level required by the state, and (4) stop loss recoveries and amounts recoverable are deducted from incurred claims.

14. Section 438.8(e)(2)(iii)(A) provides that incurred claims used in the MLR calculation include, “Payments made by a health plan to mandated solvency funds.” This is not a claim payment (at least until it comes out of the solvency fund to pay the claims of an insolvent insurer). It may be better to call it an item that can be placed in the numerator of the MLR calculation, alongside the incurred claims, rather than to call it an incurred claim.
15. Section 438.8(e)(2)(iii)(B) provides that incurred claims used in the MLR calculation include, “The amount of incentive and bonus payments made to network providers.” This should not be limited to payments made; accruals for amounts expected to be paid should be included.
16. Section 438.8(e)(2)(iv)(A) provides that, “net payments or receipts related to risk adjustment and risk corridor programs” are amounts to be included in or deducted from incurred claims. For many states, the premiums originally paid to the health plans are risk adjusted on a prospective basis, so this provision would be applicable only to retrospective applications of risk adjustment. Please clarify if this is correct. With respect to risk corridors, the language has the effect of presuming that risk corridor programs operate by comparing actual medical claims to a target. While this is likely true for most, some risk corridor programs could include an administrative expense component. For example, the actual expense used in the risk corridor arrangement could be incurred claims plus administrative expense, possibly with some limits on the amount of administrative expense that would be recognized. In such cases, treatment as an addition or subtraction from premium would be more consistent with that particular risk corridor arrangement.
17. Section 438.8(f)(2)(i) provides that the premium revenue used in the MLR calculation include, “Capitation payments.” Please clarify that this should include amounts that are accrued but not yet paid.
18. Section 438.8(f)(2)(ii) provides that the premium revenue used in the MLR calculation include, “State-developed one time payments, for specific life events of enrollees capitation payments.” Please clarify that this should include amounts that are accrued but not yet paid.
19. Section 438.8(f)(2)(iv) provides that the premium revenue used in the MLR calculation include, “Unpaid cost-sharing amounts that the health plan ... could have collected from enrollees under the contract, except those amounts the health plan ... can show it made a reasonable, but unsuccessful, effort to collect.” Cost sharing for specific services – office visits, ER visits, drugs – is usually collected by the provider, not the health plan. The exception is the staff model HMO. Furthermore, the provider or health plan cannot legally withhold services in most circumstances for unpaid cost sharing. Premium cost sharing is usually administered by the state as part of the eligibility process, not by the health plan. Please clarify that this section refers solely to the MCO, PIHP, or PAHP collecting cost-sharing amount that would stay with the organization, not amounts that would go to the professional or facility provider.
20. Section 438.8(f)(2)(v) provides that the premium revenue used in the MLR calculation include, “All changes to unearned premium reserves.” This language sounds like it is defining earned

premium to be premium the health plan collected in the MLR reporting year (regardless of the month of risk the premium was for) plus the estimate of uncollected premium at the end of the reporting year minus the estimate of uncollected premium at the beginning of the reporting year. We suggest using the earned premium for the MLR reporting year – the collected portion plus any needed accrual for earned but uncollected premium as of the end of the runout period.

21. Section 438.8(f)(3) describes “Federal and State taxes and licensing and regulatory fees.” There are also taxes and fees assessed at, or that vary by, the local (city and county) level. The New York City taxes and the Covered Lives Assessment in New York State are examples. The wording should be expanded to say “Federal, State, and local taxes and licensing and regulatory fees.”
22. In Section 438.8(f)(3), please confirm that ACA Section 9010 HIPF is a federal regulatory fee to be excluded from adjusted premium revenue. We note that the HIPF is assessed on the basis of calendar year (called the “data year”) premiums, with payment due in the subsequent year (called the “fee year”). The 12-month period used for the MLR calculation is not necessarily the calendar year, so premium adjustments for the HIPF and related tax costs, which may be made to either data year or fee year premiums, may require accruals of the estimated amount of the premium adjustment.
23. Section 438.8(i) indicates that the MLR calculation will be aggregated for all eligibility groups under the contract, “unless the State requires separate reporting and a separate MLR calculation for specific populations.” Some assumptions, such as administrative expense assumptions, are set at the contract level and are then allocated across eligibility groups rather than being determined at the eligibility group level. If all assumptions used in developing capitation rates are not set using the same eligibility groupings as the MLR calculation, expected results may not be consistent with MLR requirements for all eligibility groups. In such cases, it may not be appropriate to use the MLR results for other purposes, such as actual to expected analysis or for remittance requirements. In addition, applying the MLR requirements at the contract level would enhance credibility of the calculation.
24. Section 438.8(i) provides that the MLR calculation is to be performed on the “aggregate data for all Medicaid eligibility groups covered under the contract with the State unless the State requires separate reporting and a separate MLR calculation for specific populations.” Please clarify if aggregation is allowed across contracts if the health plan has multiple contracts for different eligibility group with the state (for example, one contract for TANF, another for ABD). Should the aggregation be dependent on whether the contracts have the same contract year or are priced in a similar fashion? Would states be permitted to develop an MLR-based premium rebate calculation that combines incurred claims across two or more contracts for comparison to adjusted premium combined across those contracts? Please also clarify how the MLR provisions would apply to three-way contracts involving CMS for Medicare, a state (with federal participation) for Medicaid, and an MCO that cover persons eligible for both Medicare and Medicaid. For example, dual eligible Special Needs Plans (D-SNPs) have integrated (Medicare and Medicaid combined) benefits and are regulated as both Medicare Advantage and Medicaid. Which MLR requirements will apply? How would the MLR calculations and any MLR-based premium rebates coordinate between the Medicare Advantage and Medicaid requirements?
25. Section 438.8(k)(2) requires that MLR calculations be submitted to the state within 12 months of the end of the reporting period. Some types of payments can be completed slowly — maternity case rate payments, incentive and withhold payments, pharmaceutical rebates, and reporting from subcontractors. Please clarify that, while an initial MLR report is due within 12 months of the end

of the reporting period, states can delay the final calculation of the amount of any premium to be rebated until a later MLR calculation is performed. This would have the benefit of ensuring that any estimate of IBNR or other accruals is minimal.

Key Points Summary

1. The Academy's Medicaid Subcommittee supports necessary additional capitation rate development transparency and documentation requirements. As requested by CMS, several comments and questions regarding specific aspects of CMS-2390-P are included in this letter.
2. Timing of implementation and cost and burden to states and their staff are of significant concern.
3. The subcommittee stands ready, and offers any assistance desired by CMS, in working through details associated with "Rate-setting" (Sections 438.2 through 438.7) and "Medical Loss Ratio (MLR)" (Section 438.8).

The subcommittee welcomes the opportunity to speak with you about any of the items discussed in this letter, and offers assistance on any desired topic. If you have any questions or comments, please contact David Linn, the Academy's health policy analyst (202-223-8196, linn@actuary.org).

Sincerely,

Michael E. Nordstrom, MAAA, ASA
Chairperson, Medicaid Subcommittee
American Academy of Actuaries