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ACAP ACTUARIAL SOUNDNESS PROPOSAL

Rate adequacy is fundamental to a functioning Medicaid risk-based system and is necessary for managed care organizations (MCO) to ensure ongoing access to high quality services for members. The Balanced Budget Act of 1997 provides the Centers for Medicare and Medicaid Services (CMS) with the authority to ensure rate adequacy by stating that no payment shall be made to a MCO for Medicaid enrollee services unless the contract between the state and MCO for those services provides for actuarially sound prepaid payments. The statute further requires the Secretary of the Department of Health and Human Services (DHHS) to provide prior approval for these contracts.

Rules promulgated by CMS in June 2002 provide additional guidance on the meaning of "actuarially sound capitation rates." According to the regulations, rates that are actuarially sound must have been developed in accordance with generally-accepted actuarial principles and practices; are appropriate for the populations to be covered and the services to be furnished under the contract; and have been certified as meeting the requirements of the regulation by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board. The preamble to the 2002 rule also contains language indicating that states must develop rates independent of the state budget, basing rates instead on the expected cost of delivering managed care to each state's Medicaid populations.

To uphold the regulations, CMS regional offices review Medicaid managed care capitation rates set by states using an "actuarial checklist" that requires states to describe their rate setting methodology and the data used to arrive at rates, provide an actuarial certification of the capitation rates and payments under the contract, and give additional information. CMS approves rates for MCOs that adhere to this checklist.

However, more can be done to ensure that actuarial soundness provisions are consistently followed. Specifically, there is no requirement for transparency in the state rate setting process; states are not required to share the medical cost and utilization trend data and other assumptions that are critical to evaluating the actuarial soundness of managed care rates. Without this information, MCOs have no ability to reconcile state and plan data, to challenge individual components of the rates, or to question the adequacy of the rates in their totality.

While some states recognize the need for transparency, others have not. A report by The Lewin Group entitled *Rate Setting and Actuarial Soundness in Medicaid Managed Care* found that among the MCOs studied, plans in one-half of the states indicated that payment rates are either explicitly budget-driven or are indirectly affected by budget constraints. In addition, thirty-nine percent of the plans (representing 5 of the responding states) say that the state generally is not responsive to their concerns about the rate-setting process, and that the final rates often do not reflect all the factors that could have a material impact on the plans' cost of providing benefits.

Moreover, there is no administrative process for a MCO to challenge whether rates have been set in an actuarially sound manner. In many cases, CMS Regional Offices have relied on a mechanical application of the checklist and have not exercised oversight responsibility as long as an actuary certification letter has been submitted by a state, even in cases where there were obvious flaws.

This fails to recognize the reality that states are under extreme budgetary pressure to reduce costs beyond what is called for under principles of actuarial soundness. In addition, given the contractual dependence between the state and the contracted actuary, there is a natural tendency for vendors to err on the side of meeting the needs of their customers. While the August 2005 practice letter issued by the American Academy of Actuaries (AAA) provides professional guidance and notes "the actuary would usually be prudent to select assumptions that are individually reasonable and appropriate when deriving the final premium rates," they do not *require* actuaries and states to follow particular practices.

As a result, MCOs faced with rates that are not actuarially sound and cannot be challenged in a meaningful way are left with the choice of taking the disruptive step to exit the state market, or for those committed to the community they serve, taking a potentially more dangerous course of attempting to survive with inadequate rates.

RECOMMENDATIONS

- **Issue a State Medicaid Director's letter defining how actuarial soundness is measured by CMS and clarifying the need for transparency in the managed care rate setting process as a means to foster actuarial soundness.**

- At a minimum, states should be required to make available the following information to contracted plans:
    - Source for base cost and utilization data and justification for reliability;
    - Time period for baseline data;
    - Inflation factors used for trending from baseline period;
    - Trend projections for medical costs and caseload projections by rate cell;
    - Detailed explanation of programmatic adjustments to account for benefit or eligibility changes;
    - Detailed explanation and basis for other adjustments (for example, demonstration of attainability of any efficiency factor used in current and prior rate year); and
    - Detailed explanation of the risk-sharing methodology or assumptions or any changes to those assumptions.
- It should be noted that most of this information (source of base data; medical cost and utilization trend data or use of national/regional market basket applicable to the state and population, the justification for the predictability of the inflation rates, the documented differentiation of trend rates; and the impact of programmatic changes) is required to be provided to CMS to facilitate the checklist analysis of the rate-setting process. ACAP is only suggesting that information that is not proprietary and used by a state to determine rates should be made available for review.
- MCOs should have a minimum of 30 calendar days to review and comment on the actuarial assumptions.

- **While it is recognized that states are responsible for administering the Medicaid program and that CMS will give deference to states, CMS should establish an administrative channel for MCOs to raise issues concerning the actuarial soundness of state managed care rates, in line with their statutory oversight responsibilities.**
    - If a MCO has a good faith belief that rates are not actuarially sound, we advocate that the following informal process be available:
        - MCO raises issues and concerns in writing to the state;
        - If the issues are not resolved at this stage within a 30 day timeframe, the MCO can request a review of the rate-setting process by CMS Regional Office;
        - CMS would request a written response to the issues raised from the state;

- CMS would review the objections raised by the MCO(s) and the state responses to make a determination whether the rate-setting process resulted in actuarial sound rates;
- **As part of the oversight process and to insure a neutral assessment of actuarial soundness, CMS should utilize the services of an independent actuary (either the CMS Office of the Actuary or an actuary under contract to CMS) to evaluate the claims of the managed care plans against the information provided by the state actuary.** The independent actuary would be responsible for reviewing and opining on the validity of the assumptions and methodologies used within a 30 day timeframe. It should be noted that ACAP believes that mandatory use of an independent actuary during the initial Regional Office review process would eliminate issues at an earlier stage of the process; and
- If CMS determines that the process did not result in actuarially sound rates, the State would be notified in writing to revisit the process and resulting rates. If a State refuses to undertake such a review, it would become a State Plan compliance issue identified in the course of CMS oversight activities, as defined in 42CFR430.35c, and subject to a loss of FFP.

➢ If CMS determines that the process did result in actuarially sound rates, the MCO would still have the right to seek redress through any formal adjudication process that may exist at the State level.