



ACTUARIAL STANDARDS BOARD

● EXPOSURE DRAFT ●

**Proposed
Actuarial Standard
of Practice**

**Medicaid Managed-Care Capitation
Rate Development and Certification**

**Comment Deadline:
May 15, 2014**

**Developed by the
Medicaid Rate Setting and Certification Task Force of the
Health Committee of the
Actuarial Standards Board**

**Approved for Exposure by the
Actuarial Standards Board
December 2013**

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TO: Members of Actuarial Organizations Governed by the Standards of Practice of the Actuarial Standards Board and Other Persons Interested in Medicaid Managed Care Capitation Rates and their Certification

FROM: Actuarial Standards Board (ASB)

SUBJ: Proposed Actuarial Standard of Practice (ASOP)

This document contains the exposure draft of a proposed actuarial standard of practice, *Medicaid Managed-Care Capitation Rate Development and Certification*. Please review this exposure draft and give the ASB the benefit of your comments and suggestions. Each response will be acknowledged, and all responses will receive appropriate consideration by the drafting committee in preparing the final document for approval by the ASB.

The ASB accepts comments by either electronic or conventional mail. The preferred form is e-mail, as it eases the task of grouping comments by section. However, please feel free to use either form. If you wish to use e-mail, please send a message to **comments@actuary.org**. You may include your comments either in the body of the message or as an attachment prepared in any commonly used word processing format. **Please do not password protect any attachments.** Include the phrase “ASB COMMENTS” in the subject line of your message. Please note: Any message not containing this exact phrase in the subject line will be deleted by our system’s spam filter.

If you wish to use conventional mail, please send comments to the following address:

Medicaid Managed Care
Actuarial Standards Board
1850 M Street, NW, Suite 300
Washington, DC 20036

The ASB posts all signed comments received to its website to encourage transparency and dialogue. Unsigned or anonymous comments will not be considered by the ASB nor posted to the website. The comments will not be edited, amended, or truncated in any way. Comments will be posted in the order that they are received. Comments will be removed when final action on a proposed standard is taken. The ASB website is a public website and all comments will be available to the general public. The ASB disclaims any responsibility for the content of the comments, which are solely the responsibility of those who submit them.

Deadline for receipt of responses in the ASB office: **May 15, 2014**

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Background

This ASOP was developed to establish guidance and standards for actuaries preparing capitation rates for Medicaid programs including those certified under 42 CFR 438.6(c). Since the federal regulations took effect, actuaries have used various methods to prepare the capitation rates. This ASOP incorporates the appropriate aspects of these methods to establish guidance and considerations in the rate development process.

In August 2005, the Health Practice Council released a Practice Note, “Actuarial Certification of Rates for Medicaid Managed Care Programs.” The practice note provides non-binding guidance, background, and answers to commonly asked questions regarding the actuarial certification under 42 CFR 438.6(c). Actuaries may obtain additional information from the practice note.

Request for Comments

The task force appreciates comments on all areas of this proposed ASOP and would like to draw the readers’ attention to the following areas in particular:

1. This ASOP has been prepared to apply both to actuaries developing actuarial statements of opinion for a Medicaid MCO and to actuaries developing rate certifications under 42 CFR 438.6(c). Is this appropriate? Or should the ASOP be limited to actuaries developing rate certifications under 42 CFR 438.6(c)?
2. As written, this ASOP applies to Children’s Health Insurance Program (CHIP) managed-care capitation rate development. Is this appropriate?
3. Is the definition of “actuarial sound/actuarial soundness” in section 2.1 clear?
4. Is section 3.2.16, which discusses the actions required of the certifying actuary if the underlying data is identified to be inaccurate or incomplete, clear and appropriate?
5. Does the ASOP restrict practice inappropriately?
6. Does this ASOP provide sufficient guidance to actuaries practicing in these areas?
7. Does this ASOP provide sufficient guidance to actuaries in identifying and addressing potential inconsistencies in the expectations of actuaries working for Medicaid MCOs and those actuaries working for State Medicaid Agencies?

The ASB voted in December 2013 to approve this exposure draft.

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Task Force on Medicaid Rate Setting and Certification

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The ASB establishes and improves standards of actuarial practice. These ASOPs identify what the actuary should consider, document, and disclose when performing an actuarial assignment.

The ASB's goal is to set standards for appropriate practice for the U.S.

PROPOSED ACTUARIAL STANDARD OF PRACTICE
MEDICAID MANAGED-CARE CAPITATION RATE DEVELOPMENT AND
CERTIFICATION

STANDARD OF PRACTICE

Section 1. Purpose, Scope, Cross References, and Effective Date

1.1 Purpose—This actuarial standard of practice (ASOP) provides guidance to actuaries when performing professional services related to Medicaid and Children’s Health Insurance Program (CHIP or Title XXI) managed-care **capitation rates**, including a certification on behalf of a state to meet the requirements of 42 CFR 438.6(c).

1.2 Scope—This standard applies to actuaries performing professional services related to Medicaid managed-care **capitation rates**, including a certification on behalf of a state to meet the requirements of 42 CFR 438.6(c).

This standard also applies to actuaries performing professional services related to managed-care **capitation rates** for CHIP. Throughout this standard the term “Medicaid” also refers to CHIP.

If the actuary departs from the guidance set forth in this standard in order to comply with applicable law (statutes, regulations, and other legally binding authority) or for any other reason the actuary deems appropriate, the actuary should refer to section 4.

1.3 Cross References—When this standard refers to the provisions of other documents, the reference includes the referenced documents as they may be amended or restated in the future, and any successor to them, by whatever name called. If any amended or restated document differs materially from the originally referenced document, the actuary should consider the guidance in this standard to the extent it is applicable and appropriate.

1.4 Effective Date—This standard is effective for opinions and certifications issued on or after four months following adoption by the Actuarial Standards Board.

Section 2. Definitions

The terms below are defined for use in this ASOP.

2.1 Actuarially Sound/Actuarial Soundness—Medicaid **capitation rates** are “actuarially sound” if, for business for which the certification is being prepared and for the period covered by the certification, projected **capitation rates**, and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and

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investment income. For purposes of this definition, costs include, but are not limited to, health benefits; health benefit settlement expenses; administrative expenses; government-mandated assessments, fees, and taxes; and the cost of capital.

- 2.2 Base Data—The **base data** represents the historical data set used by the actuary to develop the **capitation rates**. The data may be from Medicaid fee-for-service data, **MCO** data, or from a comparable population data source.
- 2.3 Capitation Rate—A monthly fee paid for each member assigned or each event (for example, maternity delivery) regardless of the number or actual cost of services provided under a system of reimbursement for **MCOs**. **Capitation rates** can vary by member based on demographics, location, covered services, or other items. **Capitation rates** can be structured so that an **MCO** is fully at risk, or so that an **MCO** shares the risk with the state or with other **MCOs**.
- 2.4 Disproportionate Share Hospital (DSH) Payments—Hospitals that serve a large number of Medicaid or uninsured patients may be considered disproportionate share hospitals and may be eligible to receive additional payments under Medicaid. These payments may be subject to a hospital-specific limit. An annual allotment to each state limits Federal financial participation. Section 1923(i) of the Social Security Act requires direct payment of DSH payments and prohibits DSH payments made by **MCOs**.
- 2.5 Encounter Data—Information about an interaction between a provider of health care services and a member that is documented through the submission of a claim to an **MCO**, and shared between the **MCO** and the state Medicaid agency.
- 2.6 Enhanced or Additional Benefits—Benefits offered by **MCOs** to their Medicaid members that are above and beyond the benefits offered by the state Medicaid plan. Common examples are adult dental services, non-emergency transportation, and adult vision services.
- 2.7 Federally Qualified Health Centers (FQHC)—A federally qualified health center is (1) an organization that receives grants under Section 330 of the Public Health Service Act; (2) an organization that does not receive a grant under the Section 330 of the Public Health Service Act, but otherwise meets all requirements to receive such a grant; or (3) an outpatient health clinic associated with tribal or Urban Indian Health Organizations (UIHO); and has applied for recognition and been approved as a federally qualified health center for Medicare and Medicaid, as described in Sections 1861(aa)(3) and 1905(l)(2) of the Social Security Act. Payments to these organizations are subject to requirements set forth in Section 1902(bb) of the Social Security Act.
- 2.8 Intergovernmental Transfers (IGTs)—A transfer of public funds between governmental entities (for example, county government to state government or state university hospital to state Medicaid agency).

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- 2.9 Managed-Care Organization (MCO)—The entity contracting with the state Medicaid agency to provide health care services for selected subsets of the Medicaid population.
- 2.10 Medical Education Payments—Payments for graduate medical education as part of the rate structure for inpatient hospital payments or as **supplemental payments** under 42 CFR 447.272. These payments may include direct (GME) or indirect (IME) costs for medical education. These payments may be included as part of Medicaid managed-care **capitation rates** or may be made directly to providers for managed-care enrollees.
- 2.11 Minimum Medical Loss Ratio—A provision that requires the **MCO** to use no less than a stated portion of its earned premium for defined medical or care management expenditures.
- 2.12 Performance Incentive—A payment mechanism under which an **MCO** may receive funds in addition to the **capitation rates** for meeting targets specified in the contract between the state and the **MCO**.
- 2.13 Performance Withhold—An amount included in the **capitation rates** that is paid if the **MCO** meets certain state requirements, which may be related to quality or operational metrics. The amount may be withheld or paid up front with the monthly **capitation rate**.
- 2.14 Rating Period—Time period for which managed-care Medicaid **capitation rates** are being developed.
- 2.15 Risk Adjustment—The process by which relative risk factors are assigned to individuals or groups based on expected resource use and by which those factors are taken into consideration and applied.
- 2.16 Rural Health Clinics (RHC)—Clinics that meet certain requirements for providing primary care services in specific areas, as outlined in the Public Health Service Act and defined in Section 1905(l)(1) of the Social Security Act. Medicaid payment rates to RHCs may be specified in legislation or statute.
- 2.17 State Plan Services—The benefits provided to Medicaid beneficiaries who are eligible under a qualifying category of Medicaid assistance in a state.
- 2.18 Supplemental Payments—Payments in addition to the Medicaid fees made by states directly or through the **MCOs** to providers of Medicaid services. These payments are usually made to hospitals, but other provider types may also qualify for such payments. These payments are sometimes reciprocation for the provider paying a special tax or assessment fee.

Section 3. Analysis of Issues and Recommended Practices

- 3.1 **Overview**—An actuary may be developing, certifying, or reviewing Medicaid Managed-Care **capitation rates** on behalf of a state Medicaid agency or an **MCO**.

Title 42 CFR 438.6(c) requires that **capitation rates** paid by the state to the **MCOs** be certified as actuarially sound. The soundness opinion applies to all contracted **capitation rates**. However, the actuary is not certifying that the underlying assumptions supporting the certification are appropriate for an individual **MCO**.

An actuary employed by a contracting **MCO** may be required to develop and submit a **capitation rate** to the state Medicaid agency for a **rating period**. While the federal regulation 42 CFR 438.6(c) does not extend to an **MCO** actuary, the **MCO** actuary may be required under the terms of a proposal or contract to submit an actuarial opinion for the **capitation rates** that may or may not indicate compliance with 42 CFR 438.6(c).

- 3.2 **Medicaid Managed-Care Capitation Rate-Development Process and Considerations**—The actuary should address the following when developing **capitation rates**.

3.2.1 **Form of the Capitation Rates (Single Rate or Capitation Rate Ranges)**—The **capitation rate** certification may apply to a single point estimate **capitation rate** or range of **capitation rates**. If a range of **capitation rates** is prepared, the contracted rates with an **MCO** may be at either end of the range or a point within the range.

3.2.2 **Structure of the Medicaid Managed-Care Capitation Rates**—**Capitation rates** are usually separately developed and paid in individual **capitation rate** cells based on characteristics that cause costs to differ materially. Examples of these characteristics include age, gender, geographic region, eligibility for Medicare benefits, diagnosis or **risk adjustment** factors, and **MCO** differences. In determining the rating structure, the actuary should consider how well the structure aligns capitation revenue and **MCO** risk as well as the complexity of the rating structure. A certification of the **capitation rates** under 42 CFR 438.6(c) applies to each of the individual **capitation rate** cells.

3.2.3 **Rebasing and Updating of Rates**—When developing **capitation rates** for subsequent **rating periods**, the actuary should either rebase the rates or update existing rates. Rebasing of rates generally refers to using **base data** from a more recent time period to develop **capitation rates** along with updating assumptions used to develop the rates. Updating of rates involves adjusting existing rates to reflect the impacts of any program, benefit, population, trend, or other changes between the **rating period** of the existing rates and the **rating period** of the updated rates.

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The actuary should consider the following in making the determination whether to rebase rates or update existing rates: availability of updated data, likely materiality of rebasing, changes in the underlying population, quality of data since the last rebasing, and time elapsed since the last rebasing.

- 3.2.4 Base Data—The actuary should use **base data** (for example, population, benefits, provider market dynamics, geography) that is appropriate for the program for which **capitation rates** are being developed. The **base data** may span more than one year.

The actuary should use **base data** sources for utilization or unit cost that are relevant to the given Medicaid population and appropriate for the given use. Program-specific historical experience from the following sources are examples of **MCO** data that may meet these criteria:

- a. financial reports;
- b. summary **encounter data** reports;
- c. **encounter data** with payment information;
- d. **encounter data** without payment information;
- e. sub-capitation payment information; and
- f. provider settlement payment reports.

If the managed-care program is new or if previously carved-out services are to be included in the rates, the actuary may need to use alternative data sources. Such alternative data sources typically include fee-for-service experience and experience from other states, although other sources may be appropriate. That experience may be available in several forms, including the following:

1. financial reports;
2. summary claims data reports;
3. raw claims data with payment information; and
4. state-specific-provider settlement payment reports.

If the covered population is new, the actuary should identify data sources for similar populations and make appropriate adjustments.

- 3.2.5 Covered Services—In determining covered services, the actuary should include **state plan services** that form the basis for the claims experience used to develop

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the rates. The actuary should identify any material historical or anticipated changes to Medicaid covered services so that appropriate adjustments can be made to the claims experience. The actuary should also identify any special payments to providers (for example, **supplemental payments** or bonuses) and ensure that these payments are handled consistently between the **base data** and the **capitation rates**. Non-state plan services may be included in the **capitation rate** if the service is provided in lieu of a state plan service. If a certification is prepared under 42 CFR 438.6(c), enhanced or additional services should not be included in the rate development and should be excluded from the data used to develop the **capitation rates**, unless provided for by a waiver.

3.2.6 Base Data Period Adjustments—The actuary should consider **base data** period adjustments of the following three types:

- a. Retroactive Period Adjustment—The retroactive period adjustments reflect changes that occurred during the **base data** period to standardize the data over the **base data** period.
- b. Interim Period Adjustments—The interim period adjustments reflect changes that occurred between the **base data** period and the **rating period**.
- c. Prospective Period Adjustments—The prospective period adjustments reflect changes that will occur in the **rating period**.

3.2.7 Other Base Data Adjustments—The actuary should consider other **base data** adjustments, which may include the following:

- a. Missing Data Adjustment—Circumstances that may cause data to be missing include, but are not limited to, the following:
 1. certain claims are not processed through the same system as the **base data**;
 2. Medicaid fee-for-service data may not include all services or expenses to be covered by the **capitation rate**; or
 3. Medicaid **encounter data** may not reflect services that are sub-capitated and not reported through the **encounter data** system.
- b. Incomplete Data Adjustment—The incomplete data adjustment reflects claims that were in course of settlement, claims that were incurred but not reported, or amounts that are due for reinsurance or claim settlements.
- c. Population Adjustment—The population adjustment modifies the **base data** to reflect differences between the population underlying the base period and the population expected to be covered during the **rating period**.

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- d. Funding or Service Carve-Out Adjustments—The funding or service carve-outs are not the financial responsibility of the **MCO**. Funding carve-outs may include graduate **medical education payments**, **disproportionate share hospital payments**, or provider taxes. Service carve-outs reflect services that will not be covered by the **capitation rate**.
 - e. Retroactive Eligibility Adjustments—Medicaid beneficiaries are often provided retroactive eligibility coverage for a period prior to submitting an application for Medicaid coverage. The retroactive eligibility adjustment reflects the exclusion of periods of retroactive eligibility, if any, that are not the responsibility of the **MCO**.
 - f. Program, Benefit, or Policy Adjustments—The program, benefit, or policy adjustments reflect differences in benefit or service delivery requirements between the base period and the **rating period** that impact the financial risk assumed by the **MCO**.
 - g. Data Smoothing Adjustments—The data smoothing adjustments address anomalies or distortions in the **base data**, such as large claims or limited enrollment.
- 3.2.8 Claim Cost Trends—The actuary should include appropriate adjustments for trend and may consider a number of elements in establishing utilization and unit cost trends. Medicaid utilization trend rates may be particularly affected by changes in demographics and benefit levels, and policy or program changes. Medicaid unit cost trends may be particularly affected by changes in state-mandated reimbursement schedules (if applicable), Medicaid fee-for-service fee schedules, and provider contracting performed by the **MCOs**. Trend should be exclusive of other adjustments.
- 3.2.9 Managed-Care Adjustments—The actuary may apply managed-care adjustments based on the assumption that the program will move from the level of managed care underlying the **base data** to a different level of managed care during the **rating period**. The adjustments may be to utilization, unit cost, or both, and the impact of the adjustments may be either an increase or a decrease to the **base data**. If managed-care adjustments are included, the changes reflected in the adjustments should be attainable in the **rating period**, in the actuary's professional judgment.

The actuary should consider the following when reviewing the need for and developing the managed-care adjustments:

- a. state contractual and operational requirements, and relevant laws and regulations;
- b. current characteristics of the provider markets and related economics; and

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- c. the maturity level of the managed Medicaid program.
- 3.2.10 Non-Claim Based Medical Expenditures—The actuary should consider Medicaid-specific payments that are not included in the **base data** or that are included in the **base data** but for which the historical costs do not represent future costs. The actuary should determine whether these amounts will be an expense to the **MCOs**, and if so, how the amounts should be reflected. These types of payments include, but are not limited to, the following:
- a. **disproportionate share hospital payments;**
 - b. **federally qualified health centers** or **rural health clinics** supplemental settlement payments;
 - c. **medical education payments**
 - d. **intergovernmental transfers;** or
 - e. pharmacy rebates anticipated to be collected by the **MCO**.
- 3.2.11 Non-Medical Expenses—The actuary should include amounts for appropriate non-medical expenses in the development of the **capitation rates**. The non-medical expenses may vary by **MCO**.
- a. Administration—The actuary should include a provision for administrative expenses appropriate for the Medicaid managed-care business in the state.
 - 1. Determination of Administrative Expenses—In determining administrative expenses for each rate cell, the actuary should consider the following characteristics and functions of the **MCOs** and the Medicaid program:
 - i. overall size of the **MCO** across all lines of business;
 - ii. age and length of time participating in Medicaid;
 - iii. organizational structure; and
 - iv. demographic mix of enrollees.
 - 2. Types of Administrative Expenses—The administration expense provision may account for the following:
 - i. marketing methods and competitive environment;

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- ii. claims-processing functions;
 - iii. medical management costs including those required to achieve savings from fee-for-service or prior periods assumed in the medical cost targets;
 - iv. general corporate overhead; and
 - v. other required **MCO** functions.
- b. Underwriting Gain—The actuary should include a provision for underwriting gain to provide for the cost of capital and a margin for risk or contingency. The underwriting gain provision provides compensation for the risk assumed by the **MCO**. The methods used to develop the underwriting gain provision of the **capitation rate** should be appropriate to the level of capital required and the type and level of risk borne by the **MCO**. The actuary may reflect investment income in establishing the underwriting gain component of the **capitation rate**, although an explicit adjustment is not required. Elements of investment income that the actuary may reflect include investment income from insurance operations and investment income on capital and underlying cash flow patterns.

An actuary working on behalf of an **MCO** may determine that a negative underwriting gain is appropriate for that plan's circumstances. In this case, the negative underwriting gain should be disclosed in the actuarial opinion.

- c. Income Taxes—The actuary should consider the effect of expected income taxes on the underwriting gains and investment income retained by the **MCO**.
 - d. Taxes, Assessments, and Fees—The actuary should include an adjustment for any taxes, assessments, or fees that the **MCO(s)** are required to pay out of the **capitation rates**. If the tax, assessment, or fee is not deductible as an expense for corporate tax purposes, the actuary should apply an adjustment to reflect the costs of the tax. Taxes, assessments, and fees may differ among the **MCOs** in the program. The actuary preparing a certification under 42 CFR 438.6(c) should consider the need to adjust **capitation rates** for each **MCO** to reflect each **MCO's** expected expenses for these items.
- 3.2.12 Risk Adjustment—An actuary working on behalf of the state should determine whether to adjust capitation payments to different **MCOs** by using a **risk adjustment** methodology. Considerations in making this determination include program enrollment procedures that may affect differences in risk across **MCOs** or among the populations used to develop the rates and to which the rates will be

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applied, data availability and quality, timing, and other practical considerations including cost. ASOP No. 45, *The Use of Health Status Based Risk Adjustment Methodologies*, provides further guidance. Risk-adjusted rates that may be developed from actuarially sound base rates and application of an appropriate risk-adjustment method are considered actuarially sound, even if the resulting rates fall outside of the unadjusted rate ranges or vary from the single point rates.

The actuary, whether working on behalf of the state or an **MCO**, should understand and consider the potential impact of the **risk adjustment** methodology being used, if any, on the **capitation rate**.

- 3.2.13 Reinsurance, Risk Corridors, and Other Risk-Sharing Arrangements—The actuary should consider the effect of any risk-sharing arrangements between the **MCO** and the state Medicaid agency or the federal government.

The actuary should consider how payments related to risk-sharing arrangements have been reported in the base period data, how these payments are to be estimated in the future, and how these payments will be reflected in the **capitation rates**.

- 3.2.14 Performance Withholds/Incentives—The actuary should consider how the existence of the withholds and incentives will affect the plan costs, including claims and administration costs. The **capitation rates** should reflect the value of the portion of the withholds for targets that the **MCOs** can reasonably achieve. The **capitation rates** should not reflect the value of incentives. The actuary should also consider any limitations to the amount of incentive payments or withholds specified in legislative regulations or guidance.

- 3.2.15 Minimum Medical Loss Ratios—The actuary should consider governmental and contractual **minimum medical loss ratio** requirements as well as the sharing of gains or losses. Such provisions may affect the underwriting gain provision component of the **capitation rates**.

- 3.2.16 Inaccurate or Incomplete Information Identified after Opinion or Rate Certification—If prior to the issuance of a subsequent opinion or certification the actuary determines after the opinion or certification was issued that he or she used inaccurate or incomplete information, the actuary should notify the principal if, in the actuary's professional judgment, the new information is material to the actuarial soundness of the rates and is not inherent in the assumptions already included in the rates.

- 3.3 Qualified Opinion on Actuarial Soundness—The actuary should provide a qualified opinion if the conditions outlined in section 2.1 are not all met. For example, the opinion should be qualified if a negative underwriting margin is determined to be appropriate for a specific plan's circumstance by an actuary working on behalf of an **MCO**.

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- 3.4 Documentation—The actuary should document the methods, assumptions, procedures, and sources of the data used. The documentation should be in a form such that another actuary qualified in the same field could assess the reasonableness of the work. The actuary should consider documentation to address CMS regulations specific to Medicaid managed-care **capitation rate** development and certification. For further guidance, see ASOP No. 23, *Data Quality*; ASOP No. 25, *Credibility Procedures*; and ASOP No. 41, *Actuarial Communications*.

Section 4. Communications and Disclosures

- 4.1 Communications—When issuing actuarial communications under this standard, the actuary should refer to ASOP No. 41.
- 4.2 Disclosures—The actuary should include the following, as applicable, in an actuarial communication:
- a. as required by 42 CFR 438.6(c), a statement that **capitation rates** provided with a rate certification are considered “actuarially sound,” according to the following criteria:
 1. the **capitation rates** have been developed in accordance with generally accepted actuarial principles and practices;
 2. the **capitation rates** are appropriate for the Medicaid populations to be covered, and Medicaid services to be furnished under the contract; and
 3. the **capitation rates** meet the requirements of 42 CFR 438.6(c).
 - b. a statement indicating the actuary’s qualification to provide the opinion and adherence to applicable standards of practice;
 - c. the definition of “**actuarial soundness**”;
 - d. disclosure of any items causing the opinion to be qualified such as the use of a negative underwriting gain by an actuary working on behalf of a Medicaid **MCO**;
 - d. the disclosure in ASOP No. 41, section 4.2, if any material assumption or method was prescribed by applicable law (statutes, regulations, and other legally binding authority);
 - e. the disclosure in ASOP No. 41, section 4.3., if the actuary states reliance on other sources and thereby disclaims responsibility for any material assumption or method selected by a party other than the actuary; and

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- f. the disclosure in ASOP No. 41, section 4.4, if, in the actuary's professional judgment, the actuary has otherwise deviated materially from the guidance of this ASOP.

Appendix

Background and Current Practices

Note: This appendix is provided for informational purposes only and is not part of the standard of practice.

Background

Medicaid is a program that pays for health care services for certain low-income persons in the United States and its Territories, as authorized by Title XIX of the Social Security Act. The federal and state governments cooperatively administer Medicaid. The Centers for Medicare & Medicaid Services (CMS) is the agency charged with administering Medicaid on behalf of the federal government. The federal government establishes certain requirements for Medicaid, and the states administer their own programs. The federal government and the states share the responsibility for funding Medicaid.

Medicaid programs were originally fee-for-service (FFS) programs in which the state paid the providers directly. In the 1980s, some states began to contract with managed-care organizations (MCOs) to provide health care services for selected subsets of the Medicaid population. In some cases, states may need to obtain a CMS waiver in order to waive certain Medicaid regulations and contract with MCOs. In many states, the state or its contractor develops capitation rates that are offered to the MCOs, rather than the MCOs proposing rates to the state. Under this arrangement, typically the MCOs may accept the rates or decline to participate in the program, though some negotiation may be possible.

Beginning in August 2003, the capitation rates paid by the state to the MCOs must be certified as actuarially sound under 42 CFR 438.6(c). The actuary performing the rate certification process may be an employee of the state Medicaid agency or contracted as a consulting actuary. Normally, the certifying actuary will not have as specific knowledge of each MCO's operations and experience as an actuary working on behalf of the MCO. The soundness certification applies to all contracted capitation rates. However, the actuary is not certifying that the capitation rates are appropriate for an individual MCO.

This ASOP was developed to establish guidance and standards for actuaries preparing capitation rates under 42 CFR 438.6(c). Since the federal regulations took effect, actuaries have used various methods to prepare the capitation rates. This ASOP has been developed to incorporate the appropriate aspects of these methods to establish guidance and considerations in the rate development process.

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Current Practices

The current Medicaid capitation rate setting and certification methodology varies state by state, but actuaries across the country use many of the considerations outlined in the ASOP. Actuaries rely on the August 2005 practice note, the CMS Regional Office Checklist for Actuarial Certification of Capitation Rates, and traditional health care actuarial principles in the development of the actuarially sound capitation rates.

In many states, the capitation rates are developed independently by the state Medicaid agency and the certifying actuary. The capitation rates are often offered to the contracting MCO without negotiation, but the contracting MCOs and their actuaries may have the ability to review the capitation rate development and provide comment. Further, a state Medicaid agency may negotiate rates with each MCO based on a rate range or allow a competitive bid. Due to the unique nature of these contracting arrangements, the certifying actuary has a greater responsibility in the determination of the capitation rates (either the point estimates or capitation rate ranges), since the certifying actuary is not directly affiliated with the contracted MCO.

Actuaries rely on data and information provided by the state Medicaid agency, the contracted MCOs, and other publicly available information. Actuaries may publish a data book that outlines the baseline data, adjustments to the baseline data, actuarial assumptions, and the development of capitation rates. Public meetings may be held where the capitation-rate development process is presented to the contracted MCOs. Following the public meetings, the MCOs may provide questions to the state Medicaid agency and the certifying actuary regarding the capitation-rate development process and assumptions. The certifying actuary reviews the comments and adjusts the capitation rates, if appropriate.

The state Medicaid agency presents the actuarial rate certification and related documentation to the CMS for review and approval. CMS may submit questions to the state Medicaid agency and the certifying actuary regarding the capitation-rate development and the related contract with the MCOs. The certifying actuary will often provide written responses to CMS.

Additional Resources

The following resources may assist in furthering the actuaries' understanding of the capitation rate development process.

- American Academy of Actuaries, Health Council Practice Note, *Actuarial Certification of Rates for Medicaid Managed Care Programs*, August 2005, <http://actuary.org/content/actuarial-certification-rates-medicaid-managed-care-programs>
- Centers for Medicare and Medicaid Services, Medicaid website, <http://medicaid.gov/>
- Medicaid and CHIP Payment and Access Commission (MACPAC), <http://www.macpac.gov/>
- Federal Register / Vol. 67, No. 115 / Friday, June 14, 2002 / Rules and Regulations, page 41097, Sec. 438.6 Contract Requirements (c) Payments under risk contracts, <http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/downloads/cms2104f.pdf>