ACTUARIAL STANDARDS BOARD

EXPOSURE DRAFT

Proposed Revision of
Actuarial Standard
of Practice
No. 49

Medicaid Managed Care Capitation Rates

Comment Deadline:
September 1, 2026

Developed by the
ASOP No. 49 Task Force of the
Health Committee of the
Actuarial Standards Board

Approved for Exposure by the
Actuarial Standards Board
March 2026

T A B L E O F C O N T E N T S

APPENDIX

March 2026

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

FROM: Actuarial Standards Board (ASB)

SUBJ: Proposed Revision of Actuarial Standard of Practice (ASOP) No. 49

This document contains the exposure draft of a proposed revision of ASOP No. 49, *Medicaid Managed Care Capitation Rates*. Please review this exposure draft and give the ASB the benefit of your comments and suggestions. Each written comment letter or email received by the comment deadline will receive consideration by the drafting committee and the ASB.

The ASB appreciates comments and suggestions on all areas of this proposed standard. The ASB requests comments be provided using the Comments Template that can be found here and submitted electronically to **comments@actuary.org**. Include the phrase "ASOP No. 49 COMMENTS" in the subject line of your message. Also, please indicate in the template whether your comments are being submitted on your own behalf or on behalf of a company or organization.

The ASB posts all signed comments received on its website to encourage transparency and dialogue. Comments received after the deadline may not be considered. Anonymous comments will not be considered by the ASB nor posted on the website. Comments will be posted in the order that they are received. The ASB disclaims any responsibility for the content of the comments, which are solely the responsibility of those who submit them.

For more information on the exposure process, please see the ASB Procedures Manual.

Deadline for receipt of comments: **September 1, 2026**

History of the Standard

ASOP No. 49 was first adopted in 2015 to establish guidance for actuaries preparing, reviewing, or giving advice on capitation rates for Medicaid managed care programs, including those certified in accordance with federal regulations. Since federal regulations regarding these capitation rates took effect in 2003, actuaries have used various methods to prepare Medicaid managed care capitation rates. The ASOP incorporated the appropriate aspects of these methods to establish guidance and considerations in the Medicaid managed care capitation rate development process.

Since 2015, there have been many developments in federal regulations, including implementation and subsequent revisions to the 2016 Medicaid Managed Care Final Rule.

Federal regulations, and actuarial practice, have evolved to such an extent that the guidance in the standard required revision. Therefore, the ASB decided to revise the ASOP to clarify items from the original ASOP, remove references to specific federal regulations, and ensure that the standard provides sufficient guidance to actuaries working in this market. The ASB also converted some educational language to guidance throughout the standard.

Notable Changes from the Existing ASOP

Notable changes from the existing standard are summarized below. Notable changes do not include changes made to improve readability, clarity, or consistency.

1. Section 1.2, Scope, includes additional examples of the types of work that may be in scope but does not modify the scope of the standard.

2. Section 2, Definitions, was revised to add, delete, or modify definitions.

3. Section 3.2.7.4, Enrollment Timing Adjustment, was added to replace Retroactive Eligibility Adjustments to include all types of enrollment timing events.

4. Section 3.2.11, Managed Care Adjustments, added additional items the actuary should take into account when developing managed care adjustments.

5. Section 3.2.13, Non-Benefit Expenses, was modified to include income taxes as a consideration within underwriting gain.

6. Section 3.3, Mandated Capitation or Revenue Minimums, Maximums, Increases, or Decreases, replaced the previous section on state initiatives.

7. Section 3.4, Qualified Opinion on Actuarial Soundness, was expanded to include situations where the capitation rates were adjusted based on a mandate without an appropriate adjustment contained in section 3.2.

Request for Comments

The ASB appreciates comments and suggestions on all areas of this proposed standard submitted through the Comments Template. Rationale and recommended wording for any suggested changes would be helpful.

In addition, the ASB would like to draw the readers' attention to the following questions:

1. Is the guidance clear regarding what the actuary should do when the mandated capitation or revenue minimums, maximums, increases, or decreases (see section 3.3) can or cannot be achieved through the appropriate actuarial adjustments (see section 3.2)?

2. The existing ASOP No. 49 predated the initial implementation of the 2016 Medicaid Managed Care Final Rule. Significant portions of the ASOP were subsequently codified in the federal regulations (currently 42 CFR 438). Does the exposure draft appropriately minimize duplication with federal regulations while retaining sufficient guidance and clarity?

3. The language in section 3.2.6 regarding state directed payments was generalized to meet current federal nomenclature and broadened to clarify inclusion of all types of special payments. Is the guidance clear and appropriate?

4. Specific guidance related to mid-rating period changes for programmatic items or entering/existing MCOs was considered for inclusion in the exposure draft but ultimately deemed too specific. Is this conclusion accurate?

The ASB thanks former task force members Tim Doyle and Tony Marko for their assistance during the earlier drafting of this standard.

The ASB voted in March 2026 to approve this exposure draft.

ASOP No. 49 Task Force

Jeremy Palmer, Chairperson

Marie Keiko Breyan
Bob Karsten
Julia Lerche
Taylor Pruisner
Aany Tazmin-Ewing

Health Committee of the ASB

Audrey Halvorson, Chairperson

Ashlee Mouton Borcan
Aany Tazmin-Ewing
James Lescoe
Gigi Li
D. Todd Sherman
Yixuan Song
Bruce Stahl

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Alisa L. Swann

The Actuarial Standards Board (ASB) sets standards for appropriate actuarial practice in the United States through the development and promulgation of Actuarial Standards of Practice (ASOPs). These ASOPs describe the procedures an actuary should follow when performing actuarial services and identify what the actuary should disclose when communicating the results of those services.

EXPOSURE DRAFT—March 2026

PROPOSED REVISION OF ACTUARIAL STANDARD OF PRACTICE NO. 49

MEDICAID MANAGED CARE CAPITATION RATES STANDARD OF PRACTICE

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

1.1 Purpose—This actuarial standard of practice (ASOP or standard) provides guidance to actuaries related to developing, certifying, or reviewing Medicaid (Title XIX) and Children's Health Insurance Program (CHIP or Title XXI) managed care **capitation rates**.

Throughout this standard the term "Medicaid" includes CHIP.

1.2 Scope—This standard applies to actuaries when developing, certifying, or reviewing Medicaid managed care **capitation rates** including, but not limited to, the following:

a. developing or certifying on behalf of a state to meet the federal requirements for **actuarially sound capitation rates**;

b. developing or certifying on behalf of an **MCO**, if required as a component of a **capitation rate** bid or **capitation rate** acceptance;

c. developing, certifying, or reviewing a department of insurance **capitation rate** filing;

d. reviewing or opining on behalf of an **MCO**; and

e. reviewing on behalf of a government agency.

If the actuary is performing actuarial services that involve reviewing Medicaid managed care **capitation rates**, the actuary should follow the guidance in this ASOP to the extent practicable within the scope of the actuary's assignment.

If the actuary determines that the guidance in this standard conflicts with a cross-practice ASOP (applies to all practice areas), this standard governs.

If a conflict exists between this standard and applicable law (statutes, regulations, and other legally binding authority), the actuary should comply with applicable law. If the actuary departs from the guidance set forth in this standard in order to comply with applicable law, 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 follow the guidance in this standard to the extent it is applicable and appropriate.

1.4 Effective Date—This standard is effective for work performed regarding **capitation rates** effective on or after 12 months after adoption by the Actuarial Standards Board.

Section 2. Definitions

The terms below are defined for use in this standard and appear in bold throughout the ASOP. The actuary should also refer to ASOP No. 1, *Introductory Actuarial Standard of Practice*, for definitions and discussions of common terms, which do not appear in bold in this standard.

2.1 Actuarially Sound/Actuarial Soundness—Medicaid managed care **capitation rates** are **actuarially sound** if, when taken together with other applicable revenue sources and allowable special contract provisions related to payments, they are projected to provide for all reasonable, appropriate, and attainable costs.

2.2 Capitation Rate—A fee paid regardless of the number or actual cost of services provided under a system of reimbursement for **MCOs**. **Capitation rates** are generally paid monthly for each Medicaid managed care enrollee ("enrollee") assigned or paid one time for each event (for example, maternity delivery) and can vary by individual based on demographics, location, covered services, or other characteristics.

2.3 Encounter Data—Information relating to the receipt of items or services by an enrollee that is documented through the submission of an administrative record to an **MCO** and shared between the **MCO** and the state Medicaid agency.

2.4 Enhanced, Value-Added, or Additional Benefits—Benefits offered by **MCOs** to their enrollees that are above and beyond **state plan services** or **in-lieu-of services**. Common examples are adult dental services, non-emergency transportation, and adult vision services.

2.5 In-Lieu-of Services—Benefits for services or settings approved as optional substitutes to **state plan services**.

2.6 Managed Care Organization (MCO)—An entity contracting with the state Medicaid agency to provide health care services for selected subsets of the Medicaid population. MCOs are sometimes known as "managed care plans (MCPs)"; "managed care entities (MCEs)"; "pre-paid in-patient health plans (PIHPs)"; and "pre-paid ambulatory health plans (PAHPs)."

2.7 MCO Actuary—An actuary providing actuarial services for an **MCO**.

2.8 Minimum Medical Loss Ratio—A provision that requires the **MCO** to use no less than a defined portion of its revenue for allowable benefit and non-benefit expenses as specified in the **MCO** contract.

2.9 MMC Program—A Medicaid managed care program.

2.10 Performance Incentive—A payment mechanism under which an **MCO** may receive funds in addition to the **capitation rates** for meeting targets specified in the **MCO** contract.

2.11 Performance Withhold—An amount included in the **capitation rates** that is contingent on the **MCO** meeting targets specified in the **MCO** contract that may be related to quality or operational metrics. The amount may be withheld from, or recouped if paid up front with, the monthly **capitation rate**.

2.12 Rating Period—The time period for which Medicaid managed care **capitation rates** are being developed.

2.13 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.

2.14 State Actuary—An actuary providing actuarial services on behalf of an **MMC program**.

2.15 State Plan Services—The benefits defined by the state and approved by Centers for Medicare and Medicaid Services (CMS), including benefits provided through waivers, that must be provided to enrollees who are eligible under a qualifying category of Medicaid assistance.

Section 3. Analysis of Issues and Recommended Practices

3.1 Overview—An actuary may develop, certify, or review Medicaid Managed Care **capitation rates** on behalf of a government agency, an **MCO**, or another stakeholder. Depending on the actuary's assignment, federal requirements for **actuarial soundness** may apply. If so, the actuary must have knowledge and understanding of those requirements.

Federal regulations require that all **capitation rates** paid by the state to the **MCOs** be certified as **actuarially sound**. However, the certifying **state actuary** is not certifying that the underlying assumptions supporting the certification are appropriate for an individual **MCO**.

An **MCO actuary** may be required to develop and submit **capitation rates** to the state Medicaid agency for a **rating period**. While the federal regulation 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 certification for the **capitation rates** that confirms compliance with federal regulations.

If federal regulation or other applicable law prescribes use of a definition that conflicts with the definition in section 2, the actuary must use the prescribed definition instead of the definition in section 2. Use of the prescribed definition is not a deviation from the guidance in this standard. For example, a certifying **state actuary** or reviewing CMS actuary may be required to use a federally prescribed definition of **actuarial soundness**, while a certifying **MCO actuary** may be subject to such a requirement in state law, and an actuary performing other actuarial services may not be subject to any such requirement.

3.2 Capitation Rate Development—The following guidance applies to actuaries when developing **capitation rates**.

3.2.1 Structure of the Capitation Rates—**Capitation rates** are usually developed for individual **capitation rate** cells based on characteristics that cause costs to differ materially. Examples of these characteristics include age, gender, qualifying event (for example, maternity delivery), geographic region, Medicaid eligibility group, eligibility for Medicare benefits, diagnosis or **risk adjustment** factors, and **MCO** differences. **Capitation rates** for each rate cell may be a single point estimate or a range of **capitation rates**. When determining the rating structure, the actuary should take into account how well the structure aligns capitation revenue and **MCO** risk as well as the complexity of the rating structure. For further guidance, see ASOP No. 12, *Risk Classification*.

3.2.2 Capitation Rate Ranges—When using a range of **capitation rates**, the certifying **state actuary** should confirm that **MCO** contracted **capitation rates** are within the range using the budget neutral rate (calibrated to rate cell average resource use) and not the risk adjusted rate (calibrated to **MCO** specific resource use).

3.2.3 Rebasing and Updating of Capitation Rates—When developing **capitation rates** for an **MMC program** that has existing **capitation rates** in a current or prior **rating period**, the actuary should either rebase the **capitation rates** or update existing **capitation rates**. Rebasing of **capitation rates** is the use of base data from a more recent time period to develop **capitation rates** along with updated assumptions to develop the **capitation rates**. Updating of **capitation rates** is the use of adjustments to existing **capitation rates.** When updating, the actuary should consider reflecting the impacts of any program, benefit, population, trend, or other changes between the **rating period** of the existing **capitation rates** and the **rating period** of the updated **capitation rates**.

When determining whether to update existing **capitation rates** rather than rebasing them, the actuary should take into account the following: 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 that is appropriate for the **MMC program** for which **capitation rates** are being developed. The actuary should use

base data that is sufficiently current. The base data may span more than one year. Sources of base data may include subject experience, other relevant experience, or a combination thereof.

Subject experience may include **encounter data**, detailed claims data, or financial reports representing the actual utilization or expenditures of the historically enrolled population. The data may represent an aggregate of experience for all **MCOs**, an individual **MCO**, or a combination of individual **MCOs**.

Other relevant experience may include **encounter data**, detailed claims data, or financial reports representing the historical utilization or expenditures of a comparable fee-for-service population or other comparable population.

When using other relevant experience, the actuary should use experience reflecting characteristics reasonably similar to those of the **MMC program** population, such as demographics, benefits and coverages, provider market dynamics, geography, frequency, or severity. If experience does not and cannot be adjusted to reasonably reflect the **MMC program** population, the actuary should not use that experience.

For further guidance, see ASOP No. 23, *Data Quality*, ASOP No. 25, *Credibility Procedures*, and ASOP No. 56, *Modeling*.

3.2.5 Covered Services—When developing **capitation rates**, the actuary should generally reflect services for enrollees, as specified in the **MCO** contract.

An **MCO actuary** should consider reflecting the cost of all services not specified in the **MCO** contract, including **enhanced, value-added, or additional benefits**.

However, when developing **capitation rates** that are subject to federal requirements for **actuarially sound capitation rates**, the actuary should include only **state plan services** and **in-lieu-of services**.

3.2.6 Special Payments—States may require **MCOs** to make special payments to certain providers in addition to an **MCO**-provider negotiated reimbursement structure for covered services. Special payments may be risk-based or non-risk based, claim-based or non-claim based, and are often made by the **MCOs** to hospitals and physician organizations, but other provider types may also qualify for such payments.

The actuary should take into account any special payments to providers and include these payments in the development of the **capitation rates** in a manner that reflects the state requirements for these special payments in the **rating period**.

3.2.7 Base Data Adjustments—The actuary should apply the following base data adjustments as appropriate.

3.2.7.1 Missing Data Adjustment—An adjustment to account for claims, sub-capitation, or service expenditures that were not submitted or accepted in the **encounter data** system or were not processed through the same system as the base data.

3.2.7.2 Incomplete Data Adjustment—An adjustment to account for claims that were in course of settlement, claims that were incurred but not reported, or amounts that are due for reinsurance or claim settlements. For further guidance, refer to ASOP No. 5, *Incurred Health and Disability Claims*, and ASOP No. 42, *Health and Disability Actuarial Assets and Liabilities Other Than Liabilities for Incurred Claims*.

3.2.7.3 Population Adjustment—An adjustment to modify the base data to reflect differences between the population underlying the base period and the population expected to be enrolled during the **rating period**. For example, due to individuals gaining or losing Medicaid eligibility, the pool of enrollees covered in the base and **rating periods** may change, or the average duration of enrollees may affect the costs between the base and **rating periods**.

3.2.7.4 Enrollment Timing Adjustment—An adjustment to reflect changes in individuals' enrollment timing with **MCOs**. For example, enrollees are often provided retroactive eligibility coverage for a period prior to submitting an application for Medicaid coverage. An adjustment to the base data may be appropriate if coverage during this period is not the responsibility of the **MCOs**. Another example may be a change in how quickly following the application date an individual is enrolled in an **MCO**.

3.2.7.5 Data Smoothing Adjustment—An adjustment to address anomalies or distortions in the base data, such as large claims or limited enrollment.

3.2.8 Program, Benefit, or Policy Adjustments—The actuary should apply appropriate adjustments to reflect differences in the program, benefit, or policy requirements between the base period and the **rating period**. The actuary may make such adjustments to the base data or may apply additive adjustments to the claim costs in the case of a new benefit.

When determining whether a program, benefit, or policy adjustment is appropriate, the actuary should measure the expected impact on the benefit or non-benefit cost assumed by the **MCO**, which may differ from mandated capitation or revenue minimums, maximums, increases or decreases (also see sections 3.3 and 3.4).

3.2.9 Adjustments Related to Different Time Periods—When developing the adjustments described in section 3.2.7 and 3.2.8, the actuary should develop appropriate adjustments of the following three types:

a. retroactive period adjustments to reflect changes that occurred during the base data period to standardize the data over the base data period;

b. interim period adjustments to reflect changes that occurred between the base data period and the **rating period**; and

c. prospective period adjustments to reflect changes that are expected to occur in the **rating period**.

3.2.10 Claim Cost Trends—The actuary should use appropriate claim cost trends reflecting utilization, unit costs, and service mix trend. The actuary should take into account detail by service category (for example, inpatient, outpatient, professional, behavioral health, nursing home, home care, assisted living facility, and pharmacy) and **capitation rate** cell, separated by utilization, unit costs, and service mix, if applicable, reasonably available, and credible.

When projecting future trends, the actuary should consider using historical experience as a basis for projection. When doing so, the actuary may include subject or other relevant experience data, or other appropriate data sources, and should take into account that historical trends may not be the best predictor of future trends without appropriate adjustments. For example, the actuary may make such adjustments to reflect changes in covered services or provider contracting that occurred between the beginning of the historical period and the end of the projection period. Unit cost trends may be particularly affected by changes in state-mandated reimbursement schedules, Medicaid fee-for-service fee schedules, and **MCO** provider contracts.

When claim cost trends duplicate adjustments which are otherwise individually accounted for in the **capitation rate** development, the actuary should apply normalization adjustments that mitigate such duplication.

3.2.11 Managed Care Adjustments—The actuary may apply managed care adjustments based on the assumption that the **MMC program** will move from the level of managed care efficiency underlying the base data to a different level of managed care efficiency during the **rating period**. The actuary may apply such adjustments to utilization, unit cost, service mix, or a combination thereof, and should take into account relationships among these components. For example, a decrease in inpatient untilization may be correlated with increases in outpatient utilization and both inpatient and outpatient unit cost. The actuary should only apply managed care adjustments that are reasonably attainable during the **rating period**.

The actuary should take into account the following when reviewing the need for and developing managed care adjustments:

a. applicable law;

b. state contractual and operational requirements;

c. characteristics of the provider markets;

d. the maturity level of the **MMC program**;

e. the average enrollment duration or churn of the population; and

f. historical performance against previous managed care adjustments.

3.2.12 Non-Claim Based Medical Expenditures—The actuary should take into account 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 payments will accrue to the **MCOs**, and if so, how the payments should be reflected. These types of payments may include the following:

a. disproportionate share hospital payments;

b. federally qualified health centers or rural health clinics supplemental settlement payments;

c. Certified Community Behavioral Health Clinic supplemental settlement payments;

d. medical education payments;

e. intergovernmental transfers;

f. provider payments made outside of the **MCO** claim adjudication system;

g. pharmacy rebates anticipated to be collected by the **MCO**; and

h. any non-claim based special payments as discussed in section 3.2.6.

3.2.13 Non-Benefit Expenses—The actuary should include amounts for appropriate non-benefit expenses in the development of the **capitation rates**. The certifying **state actuary** may vary non-benefit expenses by **MCO**.

3.2.13.1 Administration—The actuary should include a provision for administrative expenses appropriate for the **MMC program**. The actuary should select appropriate data sources to use as a basis for such administrative expenses, which may include specific programmatic expenses and relevant Medicaid specific or general economic benchmarks.

When determining the provision for administrative expenses, the actuary may adjust for relevant characteristics of the **MCOs** and the **MMC program**, such as the following:

a. **MCO** characteristics

i. overall size of the **MCO** across all lines of business;

ii. age and length of time participating in Medicaid; and

iii. organizational structure.

b. **MMC program** characteristics

i. age and length of time population has been enrolled in Medicaid managed care;

ii. **MCO** contractual requirements that implicitly include consideration of the administrative expense that would be required to avoid payment of monetary penalties, sanctions, or liquidated damages for noncompliance with general operational requirements;

iii. acuity and demographic mix of enrollees; and

iv. service types included in the **MMC program**.

When determining the provision for administrative expenses, the actuary may include the following types of expenses:

a. marketing;

b. claims-processing;

c. medical management costs including those required to achieve savings assumed in the **MMC program** medical cost targets, such as savings relative to fee-for-service cost or prior period cost; and

d. general corporate overhead, excluding any amounts for underwriting gain.

3.2.13.2 Underwriting Gain—The actuary should include a provision for underwriting gain, which is typically expressed as a percentage of the **capitation rate**, to provide for the cost of capital and a margin for risk or contingency. The underwriting gain provision provides compensation for

the risks assumed by the **MCO**. The actuary should use methods to develop the underwriting gain provision of the **capitation rate** that are appropriate to the level of capital required and the type and level of risk borne by the **MCO**.

When estimating the cost of capital, the actuary should select assumptions that reflect the relationship between relevant risks and rate of return. The relevant risks may include insurance, investment, inflation, and regulatory risks, as well as diversification, debt structure, leverage, reinsurance, market structure, income tax, and other appropriate aspects of the social, economic, and legal environments.

The actuary should select assumptions for the margin for risk or contingency that appropriately reflect the following:

a. the likelihood that actual experience will deviate from projected experience under moderately adverse conditions;

b. the presence, absence, and effect of special payments discussed in section 3.2.6;

c. any risk sharing arrangements, including any **minimum medical loss ratio** requirement, as discussed in section 3.2.15; and

d. **performance withholds** discussed in section 3.2.16.

When an **MCO actuary** is selecting assumptions for the underwriting gain, the actuary may include additional components beyond the cost of capital and a margin for risk or contingency. The additional components could result in a negative net underwriting gain. When including additional components, the **MCO actuary** may take into account considerations such as **MCO**-specific experience, the duration of the **MCO** contract, or **MCO**-specific business strategies and objectives.

3.2.13.3 Taxes, Assessments, and Fees—The actuary should include a provision for any taxes, assessments, or fees that the **MCOs** are required to pay out of the **capitation rates**. If such a tax, assessment, or fee is not deductible as an expense for corporate tax purposes, the actuary should adjust the provision to reflect the costs of that corporate tax. The certifying **state actuary** should consider adjusting this provision for each applicable **MCO** to reflect each **MCO's** specific taxes, assessments, and fees.

3.2.14 Budget Neutral Risk Adjustment—The certifying **state actuary** should determine whether it is appropriate to adjust capitation payments to different **MCOs** by using a budget neutral **risk adjustment** methodology. When making this determination, the actuary should take into account the **MMC program** enrollment procedures

and other dynamics that may affect differences in risk across **MCOs**, data availability and quality, timing, and other practical considerations. The actuary should also take into account the potential impact of the **risk adjustment** methodology being used, if any, on the **capitation rates**.

While **risk adjustment** methods may also be employed as part of the development of the **capitation rates**, this section only applies to the application of budget neutral **risk adjustment** to adjust capitation payments to different **MCOs**. ASOP No. 45, *The Use of Health Status Based Risk Adjustment Methodologies*, provides further guidance on the use of **risk adjustment**.

3.2.15 Reinsurance, Risk Corridors, Minimum Medical Loss Ratios, and Other Risk Sharing Arrangements—The actuary should take into account how any risk sharing arrangements or other contractual requirements may affect the risk borne by the **MCO**. The actuary should take into account how payments related to risk sharing arrangements have been reported in the base period data and any expected changes in the **rating period**.

The certifying actuary should confirm that the **capitation rates** are **actuarially sound** after consideration of these arrangements.

3.2.16 Performance Withholds and Performance Incentives—The actuary should take into account how any **performance withholds** and **performance incentives** will affect the **MCO** costs, including benefit and non-benefit costs.

The certifying actuary should confirm that the **capitation rates**, minus any portion of the **performance withhold** associated with **MCO** contract targets that are not reasonably achievable, are **actuarially sound**. The certifying actuary should not include the value of **performance incentives** in the development of the **capitation rates**. If applicable, the certifying actuary should confirm that the amounts of **performance incentive** payments or **performance withholds** satisfy any limitations specified in federal regulations.

3.3 Mandated Capitation or Revenue Minimums, Maximums, Increases, or Decreases—In cases where a component of the **capitation rates** is mandated (for example, state budget mandate), the certifying actuary must determine the appropriateness of the resulting **capitation rates** using the adjustments described in section 3.2.

3.4 Qualified Opinion on Actuarial Soundness—When certifying **actuarial soundness**, the certifying actuary should provide a qualified opinion if, in the actuary's judgment, the **capitation rates** are not **actuarially sound**. For example, the certifying actuary's opinion should be qualified if the following occurs:

a. the **capitation rates** were developed based on a mandate without an appropriate adjustment described in section 3.2; or

b. the certifying **MCO actuary** determines that a negative underwriting gain is appropriate for that **MCO's** circumstance.

3.5 Inaccurate or Incomplete Information Identified after Capitation Rate Certification—If the **state actuary** or **MCO actuary** determines after their certification was issued that they 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 **capitation rates**.

3.6 Reliance on Another Party—When relying on another party and thereby disclaiming responsibility for

a. data and other information relevant to the use of data, the actuary should refer to ASOP No. 23.

b. a model, the actuary should refer to ASOP No. 56.

c. assumptions or methods prescribed by another party, the actuary should review the assumption or method for reasonableness and consistency with other assumptions or methods to the extent practicable and appropriate within the scope of the actuary's assignment.

d. any other item not addressed above (including assumptions or methods provided, but not prescribed by another party), the actuary should review the item for reasonableness and consistency to the extent practical and appropriate within the scope of the actuary's assignment. In addition, the actuary should be reasonably satisfied that the reliance is appropriate, taking into account the following, as applicable:

1. when the other party is an actuary, whether the actuary knows that the other party is appropriately qualified and has followed applicable ASOPs;

2. whether the actuary knows that the other party has expertise in the applicable field;

3. whether the actuary knows the other party's stated purpose for the item and the extent to which it is consistent with the actuary's intended purpose; and

4. whether the actuary knows of differences of opinion within the other party's field of expertise that are material to the actuary's use of the item.

3.7 Documentation—The actuary should prepare and retain documentation to support compliance with the requirements of section 3 and the disclosure requirements of section 4. The actuary should prepare documentation in a form such that another actuary qualified in the same practice area could assess the reasonableness of the actuary's work. The amount, form, and detail of the documentation should be based on the professional

judgment of the actuary and may vary with the complexity and purpose of the actuarial services. In addition, the actuary should refer to ASOP No. 41, *Actuarial Communications*, for guidance related to the retention of file material other than that which is to be disclosed under section 4.

Section 4. Communications and Disclosures

4.1 Required Disclosures in an Actuarial Report—When issuing an actuarial report to which this standard applies, the actuary should refer to ASOP Nos. 5; 12; 23; 25; 41; 42; 45; and 56. When the actuarial report is a regulatory filing, the actuary should also refer to ASOP No. 8, *Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits*. In addition, the actuary should disclose the following in such actuarial reports, if applicable:

a. the definition of "**actuarial soundness**" (see sections 2.1 and 3.1);

b. the regulations followed to assess **actuarial soundness** (see section 3.1);

c. the sources and time periods of the base data (see section 3.2.4);

d. any enhanced, value-added, or additional benefits included (see section 3.2.5);

e. any special payments included (see section 3.2.6);

f. a description of any base data adjustments applied (see section 3.2.7);

g. any program, benefit, or policy adjustments, including any mandated capitation or revenue minimums, maximums, increases or decreases (see sections 3.2.8);

h. a summary of the claim cost trends used (see section 3.2.10);

i. a summary of any managed care adjustments applied (see section 3.2.11);

j. a summary of any non-claim expenses included (see section 3.2.12);

k. a summary of the non-benefit expenses included (see section 3.2.13);

l. a summary of any budget neutral **risk adjustment** methodology that will be applied to the **capitation rates** (see section 3.2.14);

m. a summary of any risk sharing arrangements considered in determining actuarial soundness (see section 3.2.15);

n. the magnitude of any **performance withholds** deemed not reasonably achievable (see section 3.2.16);

o. the value of any **performance incentives** included (see section 3.2.16); and

p. any items causing the opinion to be qualified such as the use of a negative underwriting gain by an **MCO actuary** or any actuarial estimate of a mandated item that differs materially from the value of the mandate for the certifying actuary (see section 3.4).

4.2 Additional Disclosures in an Actuarial Report—The actuary also should include disclosures in an actuarial report in accordance with ASOP No. 41 for the following circumstances:

a. if any material assumption or method was prescribed by applicable law;

b. 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

c. if in the actuary's professional judgment, the actuary has deviated materially from the guidance of this standard.

4.3 Confidential Information—Nothing in this standard is intended to require the actuary to disclose confidential information.

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 capitation rates to the state. Under this arrangement, typically the MCOs may accept the capitation rates or decline to participate in the program, though some negotiation may be possible.

Beginning in August 2003, federal regulations have required that the capitation rates paid by the state to the MCOs be certified as actuarially sound. The actuary performing the capitation rate certification process for a state may be an employee of the state Medicaid agency or contracted as a consulting actuary. Normally, the certifying state actuary will not have 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.

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 capitation rate development process.

Current Practices

The current Medicaid managed care capitation rate setting and certification methodology varies state to state, but actuaries across the country use many of the considerations outlined in the ASOP. Additionally, actuaries rely on Medicaid managed care capitation rate setting guidance from CMS, applicable federal regulations, 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 state 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 capitation rates with each MCO based on a capitation rate range or allow a competitive bid as part of a multi-year MCO contract. Due to the unique nature of these contracting arrangements, the certifying state actuary has a greater responsibility in the determination of the capitation rates (either the point estimates or capitation rate ranges), because the certifying state actuary is not directly affiliated with the contracted MCO. The MCO actuary may or may not be required by the state to certify the actuarial soundness of any capitation rates or bids they file with the state.

Actuaries rely on data and information provided by the state Medicaid agency, the contracted MCOs, and other publicly available information. Certifying state actuaries may publish a data book or other materials which outline the baseline data, adjustments to the baseline data, actuarial assumptions, and the development of capitation rates. Public meetings may be held annually and/or as part of a multi-year contracting process, where the capitation rate development process steps are presented to current and prospective 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 state actuary frequently reviews the comments, responds to questions, and adjusts the capitation rates, if appropriate.

The certifying state actuary creates an actuarial capitation rate certification and related documentation. These materials are then submitted by the state Medicaid agency to CMS for review and approval and may also be shared with MCOs (including their actuaries) as part of the annual contract amendment process. CMS and MCOs (frequently through their actuaries) may submit questions to the state Medicaid agency and the certifying state actuary regarding the capitation rate development and the related contract with the MCOs. The certifying state actuary will often provide written responses to these parties.

Additional Resources

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

- Centers for Medicare and Medicaid Services, Medicaid website, http://medicaid.gov/
- Medicaid and CHIP Managed Care Final Rules
  https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-final-rules
- CMS Medicaid Managed Care Rate Setting Guidance
  https://www.medicaid.gov/medicaid/managed-care/guidance/rate-review-and-rate-guides
- Medicaid and CHIP Payment and Access Commission (MACPAC)
  http://www.macpac.gov/