

**Comment #18 – 5/15/14 – 3:33 p.m.**

***Memorandum***

Date: May 15, 2014

To: Medicaid Rate Setting and Certification Task Force of the Health Committee of the Actuarial Standards Board

From: Gordon R. Trapnell

Subject: Comments on ASOP Exposure Draft “Medicaid Managed Care Capitation Rate Development and Certification”

In general, I found the proposed ASOP to be well conceived and written. Nevertheless, I think it could be improved by more precision and explanation, as indicated by comments and track changes suggestions on the attached copy of the proposed ASOP. In addition to my comments on the items for which reaction was explicitly sought, I have several additional comments set forth here.

**Additional comments**

- My only item of major disagreement is with item 3.2.11.d:
  - 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.

I interpret the last sentence to mean that an actuary retained by the state must make an explicit forecast of (i) the MCOs that will offer plans, (ii) their tax and other liabilities and (iii) their proportions of the projected enrollment. I have seen situations in which this level of information collection and forecasting precision is practical (e.g. renewing an existing program for which the state has required financial reports from MCOs that include the information on taxes) but also many others in which it is not, and I would question whether it should be the actuary’s responsibility in all situations.

In addition, this section makes the ASOP highly prescriptive of the nature and level of responsibility of the state’s actuary. The rates must cover certain liabilities of the specific plans that will participate in the state. For new rates to extend an existing program for which the state has collected the necessary information concerning MCO tax liabilities, the rule would at least be practical. But what about new programs, or open competitions through which the state wishes to attract new bidders, or at least generate the pressure on existing MCOs of potential additional competition? Could the wording of 3.2.11.d be interpreted to mean that the rates should cover the tax liabilities of any health plan that

decides it would like to participate?

In setting rates for state managed Medicaid programs the situation can vary between a new program with unknown participants to one in which the specific MCOs are known in advance. The information available for them can vary from entirely unknown to detailed financial reports obtained from the existing participating plans, depending on what the state decides on and is able to collect. The guidance in Section 3.2.11 seems to be addressing the latter situation with references to particular MCOs, e.g. “the MCOs” in item 1 (as well as item d).

By contrast with these references to details relating to the specific plans that will be participating, most of the discussion of NBE is rather vague, specifying only that the actuary’s decisions should be “appropriate”, without providing any guidance as to what might be appropriate.

Further, what is the goal? Should the objective be rates that are adequate for the current MCOs in a program, for some existing plan or plans (in the state or elsewhere), for a potential, perhaps hypothetical, MCO, or for some other universe? Isn’t this a policy question for the state to decide, rather than the responsibilities of retained actuaries? This aspect of the intended scope of the ASOP is not discussed anywhere.

In reviewing proposed rates to be offered by states for managed Medicaid programs, I have not usually seen detailed data of the kind required by Section 3.2.11.d. Hence I believe this to be a major expansion of actuarial responsibilities well beyond current practice, which I did not think was within the general mandate of this proposed ASOP. But if this is intended, the entire NBE section should be redrafted to include similar responsibilities for other items of NBE besides taxes to provide consistent guidance.

Accordingly, I recommend adding the phrase “To the extent that the information is available and such adjustments conform to the state policy with respect to the scope of appropriate adjustments, ...” at the beginning of the last sentence in Section 3.2.11.d.

- A second matter for which I think clearer guidance is needed relates to the discrepancy between the regulatory definition of actuarial soundness per the check list and that of actuaries. I do not see how professional actuaries can diverge from the mandate in the definition given in the draft that an actuarially sound rate must “provide for all reasonable, appropriate, and attainable costs”, which would include (i) administrative expenses, the cost of capital and risk premium required to attract MCOs to the business and (ii) the cost to provide any reduced cost sharing or additional benefits beyond the official State Plan filed with CMS per the statute. How does the actuary reconcile making allowances for these expenses and yet certify that the rates meet the requirements of item AA.2.4 of the check list, that explicit excludes any benefits not in the State Plan? I recognize that practicing actuaries have been coping with this problem since the check list was implemented, and would like to see some of their practices illuminated in the ASOP, perhaps providing support for their practices.
- IGTs are defined in a way that does not include what appears to be the most important and growing kind of state transfer to augment federal costs to the benefit of the state, premium taxes and insurer fees. If a state tax, the effect is the same as any other IGT. But the taxes can also provide the means for the state to subsidize counties (frequently as an explicit trade off with other transactions between the local and state governments so that the effect is no

different than a state tax) and for the federal government to require an increase in the state share of Medicaid, e.g. the new Health Insurer Fees. I recommend that the ASOP recognize their presence and importance by defining both medical and non-medical IGTs, as suggested in the comments to the text. In addition, should the actuary working for the state be advised to report separately those that have the direct effect of increasing federal share of the cost of the Medicaid program, those that increase federal and state expense (but may be a cover for a substitution for state support of local government) those that increase federal expense to the benefit of local government (by local government directly reimbursing the state for the additional state cost) or have the effect of directly increasing the state share (e.g. the new Health Insurers Fee)?

- On another matter, I think the language with respect to data quality should be addressed to reflect the nature of much of Medicaid data, which was largely produced to address state accounting and reporting needs rather than providing a suitable base for determining incurred liabilities. The primary differences relate to inconsistencies in how eligibility is recorded and how claims are recorded (and problems relating to determining the correct exposure) and items not reported to the basic claims system used by the state. For example Medicaid data may be reported on an ever enrolled basis rather than using an actuarial exposure concept. Medicaid data bases are prone to missing items, items not recorded in the basic claims data (in the “Medicaid Management Information Systems”, or MMIS), and ad hoc accounting entries (reflecting policy changes adjustments, law suits, etc.

Consequently, particular care needs to be taken (beyond that usually needed with insurance or health plan data) to assure that complete data is used as a base for capitation rates or to determine historic trends. Particular caution should be taken in interpreting trends based on cash expenditures, because these are affected by many developments characteristics of the state operating environment.

### **Specified comments**

On the other items for which reaction was explicitly sought:

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)?

I think the ASOP should be either (i) limited to those preparing certifications for the state or (ii) there should be separate sections on some items as indicated in my comments on the text (although if section 3.2.11.d is retained, perhaps there is no difference, at least with respect to NBE).

2. As written, this ASOP applies to Children’s Health Insurance Program (CHIP) managed-care capitation rate development. Is this appropriate?

Yes.

3. Is the definition of “actuarial sound/actuarial soundness” in section 2.1 clear?

Yes.

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?

Notification of the principal may not be enough. Plans may be relying on the actuarial rates despite all caveats included. I think the advice in the ASOP should be to notify the principal and urge notification of interested parties and to refile the certification to CMS with a caveat as to the data faults found.

5. Does the ASOP restrict practice inappropriately?

Note comments above.

6. Does this ASOP provide sufficient guidance to actuaries practicing in these areas?

As noted above, I think the ASOP should address potential deficiencies in state Medicaid data and problems in interpreting trends in cash data in more detail. In addition, the pervasive use of the instruction to do what is appropriate on most issues may leave the actuary without adequate guidance to cite given the relatively open interpretation of many items (other than the implications of section 3.2.11.d which I find far too restrictive).

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?

No, as discussed above.

--Gordon R. Trapnel

| [Comments and suggested changes in text in track changes for consideration by the Committee.](#)

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## **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

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, risk adjustments 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**.

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**Comment [G1]:** Capitation payments vary by risk adjustment. Is it intended to not include variation by risk adjustment in the definition of a capitation rate as opposed to a capitation payment?

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 Medical Intergovernmental Transfers (IGTs)—A transfer of public funds between governmental entities that are classified as medical expenses (for example, county government to state government or state university hospital to state Medicaid agency). They include state taxes levied on providers, but exclude taxes levied directly on MCOs.

**Comment [G2]:** For additional clarity, I suggest having separate definitions of “medical intergovernmental transfers” and “tax intergovernmental transfers” (or perhaps “non-benefit intergovernmental transfers”).

State and local government taxes on premiums or providers have the same impact as the types of transfers cited, and are an increasingly important mechanism to increase the federal level of payment, whereas the state share is either a self-payment or a transfer to local government (frequently subtracted directly from other state to local government subsidies, having the same impact as a self-payment). Taxes may affect federal and state costs in different ways, e.g. (i) those that directly increase the federal share of Medicaid expenditures to the benefit of the state (e.g. state premium tax on MCO capitations), (ii) increase both federal and state nominal expenses to the advantage of local governments (but frequently explicitly offset at the state level by a reduction in state payments to local government), (iii) any that in effect shift cost from the Federal Government to the state (such as the new ACA Health Insurers Fee, but also the federal income tax, including any provisions that such tax not be deductible) and (iv) those (if any) that do not produce a change in federal and state shares of Medicaid expenditures.

If these are not considered IGTs, I think they should be addressed as a separate subject, both for clarity and to be sure that all are addressed in developing the capitation rates.

Obviously, this definition needs to be coordinated with the discussion of taxes elsewhere.

- 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 only paid if the **MCO** meets certain state requirements, which may be related to quality or operational metrics. ↓
- 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 specified in the State Plan submitted to and approved by CMS 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 fee schedules made by states directly or through the **MCOs** to certain providers of Medicaid services. These payments are usually made to hospitals, but other provider types may also qualify for such payments (e.g. Federally Qualified Health Centers and Rural Health Clinics). These payments are sometimes reciprocation for the provider paying a special tax or assessment fee.

**Comment [G3]:** In what sense is it a withhold if paid up front?

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**Comment [G4]:** This may have a formal name in the Title XIX Statute, that must be filed with CMS. It is usually referred to as "The State Plan". Given the role of the formal State Plan in Medicaid administration and regulation, if a different meaning is intended, then different words should be used to designate the more vague concept stated here.

**Comment [G5]:** Wording needs to be tightened up. Without some limiting adverb, it could apply to all Medicaid fees.

**Comment [G6]:** Should the additional payments for E&M services be mentioned, which some states may be continuing after the ACA subsidy lapses?

### 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 that have a material effect between the **rating period** of the existing rates and the **rating period** of the updated rates.

**Comment [G7]:** I note that materiality is cited as a criterion subsequently, but including it here would improve clarity and consistency.



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

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 certain items for which MCOs will be responsible, but are not limited to, the following:
  - 1. certain claims, adjustments, and payments 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, future (expected) retroactive claim adjustments, and 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

**Comment [G8]:** Perhaps a better approach would be to have a separate paragraph that emphasizes that the base data must be adjusted to include all - and only - liabilities for which the MCOs will be responsible. This point is mentioned in several places, but a clear, direct statement of the principle would improve clarity.

**Comment [G9]:** Does this cover true up payments, e.g. to bring total compensation to FQHCs and for E&M services up to cost levels? Also, has the need to delete such additional payments if in the base data but not the contract period been covered?

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**Comment [G10]:** This opens a subject that does not appear to be covered. Do rates that include such additional services or cost sharing (not in the State Plan) meet the certification requirements?

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period and the population expected to be covered during the **rating period**.

- d. Funding or Service Carve-Out Adjustments—The funding or service carve-outs are not the financial responsibility of the MCO. Examples of funding carve-outs include, but are not limited to, graduate medical education payments, disproportionate share hospital payments, and 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 claims and eligibility for periods of retroactive eligibility, if any, that will not be the responsibility of the MCO. Actuaries should ensure that the adjustment reflects the payment policy. For example, if persons will be enrolled with MCOs on the first of the month following discharge from a hospital or other facility, claims and eligibility prior to the first of the month following discharge should be excluded from the base data.
- 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.

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**Comment [G11]:** Need to address the need for consistency of how the period of experience to be excluded is defined and how MCOs will be paid, at least on a reasonable approximation, since precision is unlikely to be feasible with typical state data. But the actuary should at least be considering this matter in devising the approximation. As written, it just says to exclude retroactive periods, not how consistent the exclusion is with how MCOs will be paid.

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3.2.8 Claim Cost Trends—The actuary should include appropriate adjustments for trend and may consider a number of elements in establishing utilization, mix of service 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, provider contracting performed by the MCOs and state changes in claim administration processes (especially toward the end of state fiscal years). Trend should be exclusive of other adjustments.

**Comment [G12]:** Shouldn't there be a section addressing the need to assure data completeness by some reconciliation with the state's accounting system (which would have to be made on a cash basis)? Or is this adequately addressed by references to the ASOP on data? I have found huge holes in state claims data, and many neglected items that became apparent only with such reconciliations.

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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.

**Comment [G13]:** Perhaps not appropriate wording, but need to emphasize that cash claims may be highly inconsistent from one period to the next.

My favorite example was a state that used a computer program to randomly chose bills not to pay. Providers kept on providing services since at least some bills were being paid. (The state displayed amazing accuracy in meeting budget projections).

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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

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** **classified as medical expenses**; or
- e. pharmacy rebates anticipated to be collected by the **MCO**.

3.2.11 Non-Medical Expenses—The actuary should include **appropriate** amounts for 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;

**Comment [grt14]:** To avoid confusion with tax IGTs. (I note that IGTs were defined earlier in a way that excludes taxes.) I recommend having separate definitions of “medical intergovernmental transfers” and “tax intergovernmental transfers” (or perhaps “non-benefit intergovernmental transfers”).

**Comment [G15]:** This section appears a bit schizophrenic. Except for the treatment of taxes paid by the MCOs, the word “appropriate” is given very heavy responsibility, resulting in little guidance. But when it comes to taxes, the actuary is expected to make a detailed forecast of the taxes that will be borne by the particular MCOs that will be offering plans. That may be appropriate when addressing the renewal of capitation rates for an existing program for which the appropriate MCO specific data is collected through a state report. But is unlikely to practical or appropriate for new programs.

Also, from the perspective of actuaries working for a state, should the objective be “feasible” for some, perhaps hypothetical, MCO, some existing MCO perhaps not offering plans in the state, the potential MCOs that might decide to offer plans in the state, or other universe? In setting state rates the situation can vary between a new program with unknown participants to one in which the specific MCOs are known in advance. The information available for them can vary from entirely unknown to detailed financial reports obtained from the existing participating plans. The guidance here seems to be addressing the latter situation with references to particular MCOs, e.g. “the MCOs” in item 1 and item d below, which requires knowledge of the tax situation of each participating MCO. Thus as written, the thrust appears to be that the rates must be adequate to cover the NME of the specific MCOs that will offer plans, which (i) may not be known in advance and (ii) requires the actuary to be in a position to assess their NME requirements, including highly detailed knowledge of their tax liabilities.

Part of the problem may stem from trying to address the responsibilities of the state actuaries and those retained by plans in the same language. Those for the plan actuaries are clear from other ASOPs, and do not need further elaboration here. Perhaps this discussion should be limited to what is uniquely covered in this ASOP, the responsibilities of the actuaries retained by states.

**Comment [grt16]:** Is it intended that “appropriate” modify the choice of the amounts or the choice of which non-medical expenses to include (or both)?

**Deleted:** appropriate

- ii. claims-processing and state reporting 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 capital and 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.

**Comment [G17]:** Capital requirements are not part of risk. Risk relates to the possibility of results different from those anticipated. Capital requirements are known in advance.

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.

**Deleted:**

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. To the extent that the information is available and such adjustments conform to the state policy with respect to the scope of appropriate adjustments, 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.

**Comment [G18]:** The reference to the 42 CFR explicitly requires the actuary retained by the state to make explicit forecasts of (i) the **MCOs** that will offer plans, (ii) their tax liabilities and (iii) their expected proportion of the enrollment. How would the details of the tax situation of each **MCO** be obtained, and the proprietary nature of the information be secured?

In reviewing rates proposed for states to offer **MCOs**, I have not usually seen such explicit forecasts; therefore I do not think it is a general characteristic of current practice. If it is intended to expand the responsibility of state actuaries to make such forecasts, I think it should be highlighted so that all interested parties can opine, not buried deep within a small item of text.

**Deleted:** T

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



applied, data availability and quality, timing, and other practical considerations including the cost to obtain more detailed data. 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.

Comment [G19]: Cost of what?

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**.

Comment [G20]: Is the intention here to be that RA should not produce an average payment rate different than the proposed rate? If so, perhaps best to say so.

- 3.2.13 Government Subsidized 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.

Comment [G21]: To avoid being confused with private reinsurance.

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 any 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.

Deleted: the

- 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**.

Comment [G22]: Does the actuary have any responsibilities if the MLR is higher than feasible for health plans (especially given item 3.2.11.d that requires explicit consideration of items very specific to the individual participating MCOs? For example, suppose a state sets the MLR at 97.5%?

- 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**.

- 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, official guidance) 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

**Comment [G23]:** e.g. as with CMS practice with Medicare Advantage.

- 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.

### 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-medicare-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>