Health Practice Council Practice Note

August 2005

Actuarial Certification of Rates for Medicaid Managed Care Programs

Developed by the
Medicaid Rate Certification Work Group of the
American Academy of Actuaries

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AMERICAN ACADEMY *of* ACTUARIES

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This group includes actuaries who have experience performing certifications to the Centers for Medicare and Medicaid Services (CMS) as either consultants to state Medicaid agencies or as state employees, and actuaries who have experience with Medicaid rates, as either employees of, or consultants to, HMOs that contract with states to provide managed health care to Medicaid populations. The work group acknowledges CMS actuary John D. Klemm for coordinating the efforts of the work group with CMS. The group would also like to thank staff at CMS who met with the work group including: Dianne Heffron, Ed Hutton, Brenda Jackson, Bruce Johnson, and Carrie Smith.

HEALTH PRACTICE NOTE 2005-1

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This practice note was prepared by a work group organized by the Health Practice Council of the American Academy of Actuaries. The work group was asked to:

> Review the Centers for Medicare & Medicaid Services (CMS) regulations that require certification of the "actuarial soundness" of Medicaid managed care premium rates;[1]
>
> Determine the extent to which the Academy has addressed the term "actuarial soundness" in any public statements (the Health Committee of the Actuarial Standards Board is reviewing the need for an Actuarial Standard of Practice on this topic); and
>
> Make a recommendation to the Health Practice Council about the best way to proceed on this issue. The work group's recommendation was to publish a practice note. The Health Practice Council approved this recommendation and directed the work to proceed with the drafting of the practice note.

The purpose of this practice note is to provide nonbinding guidance to the actuary when certifying rates or rate ranges as meeting the requirements of 42 CFR 438.6(c) for capitated Medicaid managed care programs. Examples of responses to certain situations and issues are provided. However, no representation of completeness is made; other approaches may also be reasonable and may currently be in common use. Further, appropriate alternatives to these methods may develop over time and come into common use. Events occurring subsequent to the date of publication of this practice note may make the practices described herein irrelevant or inappropriate.

Since the purpose of this practice note is to provide nonbinding guidance, this practice note has not been promulgated by the Actuarial Standards Board nor by any other authoritative body of the American Academy of Actuaries. The information in this practice note is not binding on any actuary and is not a definitive statement as to what constitutes generally accepted practice in this area. Moreover, this practice note is based upon 42 CFR 438.6(c) and current CMS requirements. To the extent that the legal requirements of a particular state impose additional or conflicting requirements, practices described in this practice note may not be appropriate for actuarial practice in that state.[2]

Comments are welcome as to the appropriateness of the practice note, desirability of updates, substantive disagreements, etc. Comments should be sent to Holly Kwiatkowski, the Academy's senior health policy analyst (federal), at kwiatkowski@actuary.org or American Academy of Actuaries, 1100 17th St. NW, 7th floor, Washington, DC 20036.

1. In this setting, the term "premium rates" refers to all payments under risk contracts and all risk-sharing mechanisms (ref. 42 CFR 438.6(c)(2)). Lump sum payments in risk contracts (and all other payments) outside of premiums are also subject to actuarial soundness certification.
2. Since these situations may exist, it is important for the actuary to bring the specific situation(s) to the attention of the appropriate state officials so a dialogue can be established to find an equitable solution.

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I. Introduction

Medicaid is a program that provides health care to indigent people in the United States under Title XIX of the Social Security Act of 1965. Created at the same time as Medicare (Title XVIII), both programs are regulated by the Centers for Medicare and Medicaid Services (CMS), an agency of the federal Department of Health and Human Services. Medicaid is financed jointly by the states and the federal government from general tax revenue, with the federal share between 50 and 80 percent of costs. The Title XXI State Children's Health Insurance Program (SCHIP) has a federal share of up to 85 percent. Primary administrative responsibility for Medicaid belongs to the state, with federal oversight. Federal rules require certain populations to be covered and a core set of services to be covered. States are permitted to expand coverage to additional populations and additional services. Medicare, in contrast, is financed and administered federally, with funds from taxes on wages, premiums paid by (or on behalf of) beneficiaries, and general tax revenue. In Federal Fiscal Year 2002, Medicaid outlays ($259 billion federal and state combined) exceeded Medicare outlays ($257 billion) for the first time.[3]

Except for some small-scale voluntary HMO enrollment in a few areas, Medicaid operated almost exclusively on a fee-for-service (FFS) basis from its inception in the 1960s until 1982. Arizona, which until that time had remained outside the Medicaid program, requested a waiver from the requirement to operate Medicaid as an FFS program. The Health Care Financing Administration (HCFA), as CMS was then called, granted Arizona's request and permitted that state to operate its Medicaid program using managed care organizations (MCOs). Other states expressed interest in using MCOs to provide Medicaid benefits, and mandatory MCO enrollment was approved in certain metropolitan areas of Minnesota, Missouri, and Wisconsin. HCFA developed a waiver process by which states could do this, with the provision that the cost of the program under managed care could not exceed the cost, known as the Upper Payment Limit (UPL), of providing the same services on a FFS basis to an actuarially equivalent non-enrolled population group. (See 42 CFR 447.361, now repealed.)

Interest in waivers for Medicaid managed care plans increased throughout the 1990s. By the late 1990s, the UPL requirement was seen as problematic. For some states, Medicaid for certain populations had been delivered exclusively through MCOs for several years, rendering FFS claim experience data on those populations out-of-date. In addition, financial requirements based on a FFS delivery system that had low levels of medical screening, vaccination, and access to health care were seen as increasingly problematic for a managed care delivery system with increased access to necessary health care services and requirements for high levels of medical screening and vaccination.

In recognition of the problem with the UPL requirement, the new 42 CFR § 438.6(c) was enacted in June 2002 to be effective for rates covering periods of August 2003 and later (see Federal Register, Vol. 67, No. 115), and § 447.361 was repealed. In summary, the requirements as stated in § 438.6 (c) are as follows:

(2) *Basic requirements.*

(i) All payments under risk contracts and all risk sharing mechanisms in contracts must be actuarially sound.

(ii) The contract must specify the payment rates and any risk sharing mechanisms, and the actuarial basis for computation of those rates and mechanisms.

(3) *Requirements for actuarially sound rates.* In setting actuarially sound capitation rates, the state must apply the following elements, or explain why they are not applicable:

(i) Base utilization and cost data that are derived from the Medicaid population, or if not, are adjusted to make them comparable to the Medicaid population.

3. Testimony of Thomas Scully, Administrator, CMS on October 8, 2003, before the House Energy and Commerce Committee Subcommittee on Health.

(ii) Adjustments are made to smooth data and adjustments to account for such factors as medical trend inflation, incomplete data, MCO, PIHP [prepaid inpatient health plan], or PAHP [prepaid ambulatory health plan] administration, and utilization;

(iii) Rate cells are specific to the enrolled population, by—

(A) Eligibility category;

(B) Age;

(C) Gender;

(D) Locality/region; and

(E) Risk adjustments based on diagnosis or health status (if used).

(iv) Other payment mechanisms and utilization and cost assumptions that are appropriate for individuals with chronic illness, disability, ongoing health care needs, or catastrophic claims, using risk adjustment, risk sharing, or other appropriate cost-neutral methods.

(4) *Documentation.* The state must provide the following documentation:

(i) The actuarial certification of the capitation rates.

(ii) An assurance that all payment rates are—

(A) Based only upon services covered under the state plan (or costs directly related to providing these services, for example, MCO, PIHP, or PAHP administration).

(B) Provided under the contract to Medicaid-eligible individuals.

(iii) The state's projection of expenditures under its previous year's contract (or under its FFS program if it did not have a contract in the previous year) compared to those projected under the proposed contract.

(iv) An explanation of any incentive arrangements, or stop-loss limits or other risk-sharing methodologies under the contract.

Section 438.6(c) defines "actuarially sound capitation rates" as capitation rates that:

- have been developed in accordance with generally accepted actuarial principles and practices;
- are appropriate for the populations to be covered and the services to be furnished under the contract; and
- have been certified as meeting the requirements of the regulation by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

Section 438.6(c) also specifies what is **not** "actuarially sound" under special contract provisions. (The practitioner may wish to refer to Sections III and IV of this practice note for additional information.) For example, the following conditions would result in payments that would not be considered "actuarially sound:"

i. If risk corridor arrangements result in payments that exceed the sum of:
   a. the amount Medicaid would have paid, on a FFS basis, for the state plan services, plus
   b. administrative costs directly related to the provisions of these services.
ii. If contracts with incentive arrangements provide for payment in excess of 105 percent of the approved capitation payments.

Section 438.6(c) requirements for "actuarial soundness" are thus a combination of two types of requirements. The first is the general requirement of being developed in accordance with generally accepted actuarial

principles and practices. The second is the potentially more restrictive requirement that CMS may impose on fiscal arrangements. This practice note concentrates on issues concerning the former. For issues concerning the latter, it is acknowledged that CMS or the states may impose additional restrictions, and this practice note, therefore, addresses only the potential areas of conflict between these requirements and generally accepted actuarial principles and practices.

In a regulation as published in the Federal Register, the section on "Comments and Responses" often is a valuable resource. This preliminary section includes such topics as CMS views on rate adequacy, the establishment of standards for risk and profit levels, and data integrity. Interpretations of these views are further detailed in Section III of this practice note.[4]

The checklist is a step-by-step tool that is expected to be used by the CMS Regional Offices to assess whether the capitation rates submitted by states are "actuarially sound" per the regulatory guidelines. For purposes of this practice note, the July 22, 2003 version of the checklist has been used. It is usually prudent to obtain the most current available version of the checklist when certifying Medicaid rates. Issues concerning risk adjustment techniques (section AA. 5.3 of the checklist) are not addressed at this time, pending the release by CMS of guidance on risk adjustment.

4. The work group that developed this practice note is fully aware of the sensitive issues surrounding the interaction of "actuarial soundness" and rate adequacy. The reader may choose to refer to Section III for a discussion of the issues that are likely to arise as one performs the task of certifying to "actuarial soundness" of rates.

II. Overview of Generally Accepted Actuarial Principles and Practices, and the Term "Actuarial Soundness"

In determining what constitutes generally accepted actuarial principles and practices, the Code of Professional Conduct and, by reference, the Actuarial Standards of Practice (ASOP) have the highest standing. Other items — such as practice notes, textbooks, examination study notes, and articles in professional journals — do not have the same standing. Currently, no ASOP applies specifically to actuarial work performed to comply with CMS requirements for rate certification. Such an ASOP would be unique among health ASOPs, in that it would address actuarial work performed for a ***purchaser*** of health plan benefit coverage. Other health-related ASOPs have scopes that apply specifically to actuarial work performed on behalf of health plans (the entities that bear the risks).[5] Some health-related ASOPs are general, so that they apply both to health actuarial work performed for health plans or to health actuarial work performed for purchasers of health plan services.[6] Certain other ASOPs are general and not specific to health work, so they could be applicable.[7] Note that ASOP 32 on Social Insurance does not apply to Medicaid. ASOP 32 applies to social insurance programs (such as Medicare, listed in the scope paragraph), which have broad-based eligibility requirements. Medicaid, which is conspicuously not included in the scope paragraph, is a public assistance program with strict income and asset eligibility requirements. The reader may wish to refer to *Social Insurance and Economic Security* by George E. Rejda, chapter 2, for more on the distinction between social insurance and public assistance.

In the ASOPs, there is only one place in which "actuarial soundness" is defined – ASOP 26*, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Benefit Plans*. That standard states:

> Actuarial Soundness — Small employer health benefit plan premium rates are actuarially sound if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums in the aggregate, including expected reinsurance cash flows, governmental risk adjustment cash flows, and investment income, are adequate to provide for all expected costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, and the cost of capital.

The published comments on the exposure draft of ASOP 26 show that the issue of whether and how to describe "actuarial soundness" of small group premium rates was a significant portion of the work performed by the committee that drafted ASOP 26. That committee noted that "many applicable laws … require the actuary to address *actuarial soundness,"* so the committee found it appropriate to address the issue. Please note, however, that the definition of "actuarial soundness" in ASOP 26, like all of the definitions in all of the standards, is specific to that standard, and does not purport to provide a definition of "actuarial soundness" for all areas and types of actuarial practice.

The above discussion of "actuarial soundness" involves knowledge concerning the health benefit plan's expected costs. An actuary working on behalf of a state Medicaid agency to form an opinion concerning the "actuarial soundness" of rates offered to MCOs would not normally have MCO-specific knowledge like that of the actuary working on behalf of the MCO. A workable assessment of "actuarial soundness" for certifications performed on behalf of state Medicaid agencies would usually take into account the following:

1. The data available to develop rates for populations with current coverage:
    - FFS data for the overall program (before introduction of MCO coverage)

5. ASOPs 3, 6, 7, 8, 10, 11, 16, 18, 19, 22, 25, 26, 28, 31, 33, and 37, as well as Actuarial Compliance Guideline (ACG) 4.
6. E.g., ASOPs 5, 12, 23, and 42.
7. E.g., ASOPs 17 and 41.

- FFS data for all but those voluntarily enrolled in an MCO (choice of one or more MCOs and a Primary Care Case Management (PCCM) or other FFS program)
- FFS data for the months before all recipients are mandated to be enrolled in an MCO
- MCO financial data and/or encounter data (utilization and cost per unit service) from a voluntary MCO enrollment period
- MCO financial data and/or encounter data from a mandatory MCO enrollment period.

2. The types of rate negotiation methods that may be in use by states, such as:
   - The state develops a range for each rate category and negotiates with each potential MCO contractor to settle on a rate within the range. This may involve MCOs submitting bids to the state for each rate cell. This likely results in rates that vary among MCOs for the same rate cell. The state may offer inducements for an MCO to bid lower than the others, such as a larger market share of those recipients who decline to select a particular MCO and must therefore be assigned to one.
   - The state negotiates separately with each MCO contractor.
   - The state develops a set of rates and contracts with MCOs that accept these rates as long as these MCOs also satisfy other requirements. Rates do not vary among MCOs, except for risk-adjusted payment methods, such as the chronic illness and disability payment system (CDPS).

3. The financial condition and operations of participating MCOs:
   - Some MCOs may be Medicaid-only and one-state-only, with no other lines of business or states over which to allocate certain administrative costs. In contrast, some MCOs may have other lines of business (Medicare Advantage, commercial group, and commercial individual) or other states' Medicaid business.
   - Some MCOs may not have gained sufficient enrollment to realize efficiencies of administration, but participation of these MCOs may still be desirable for the appropriate functioning of the state's Medicaid managed care program.
   - Some MCOs may be completely independent financial entities, while others could be wholly owned by other corporations that could control a significant portion of the administrative and reinsurance expenses being allocated to their Medicaid-participating subsidiaries.
   - Some MCOs may be for-profit entities that seek to generate a return while others could be not-for-profit MCOs.
   - Some MCOs may have arms-length negotiations with providers, while other MCOs may be owned by facility and/or professional providers.
   - Some PIHPs are government owned and may not participate in competitive procurement.[8]

The work group developed, for purposes of this practice note, the following proposed definition of "actuarial soundness" to apply to Medicaid managed care rates developed on behalf of a state for submission to CMS (based on the description in ASOP 26 shown earlier):

> Actuarial Soundness—Medicaid benefit plan premium rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums, including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income, provide for all reasonable, appropriate and attainable costs, including health benefits, health benefit settlement

8. In these instances, while there would normally be an appropriate risk allowance, CMS also believes that it is usually appropriate to use an 'excess revenues — expenses' approach on prior-approved Medicaid waiver services to Medicaid eligibles or returned to the federal government rather than offsetting other taxpayer expenses that, by statute, should not be charged to the Medicaid program (e.g., roads, bridges, stadiums, care to non-Medicaid eligibles, non-Medicaid services under 1903(i)(17) of the SSA).

expenses, marketing and administrative expenses, any state-mandated assessments and taxes, and the cost of capital.[9]

This definition is only for purposes of this practice note. It is not applicable to any actuarial practice other than actuarial certification of rates for Medicaid managed care programs and does not have the binding authority of a definition in an ASOP.

Some differences between the proposed definition above and the language in ASOP 26 are addressed in the following paragraphs.

"Governmental stop-loss" is included in the practice note description of "actuarial soundness" in recognition of non-insured stop-loss programs funded by states to cover certain costs in excess of specified amounts, or for certain types of services, or for treatment of certain medical conditions.

The words "reasonable, appropriate, and attainable" clarify that the costs of the Medicaid benefit plan do not normally encompass the level of all possible costs that any MCO might incur, but only such costs as are reasonable, appropriate, and attainable for the Medicaid program. In addition, all expected costs directly related to the Medicaid benefit plan would normally be included.

An actuary may be asked to assist a MCO by providing an opinion as to whether the rates bid by the MCO or offered by a state are "actuarially sound" for that particular MCO.[10] The analysis forming the basis of such an opinion would usually include expected costs specific to that MCO. This is a separate and distinct analysis compared to the analysis performed by the actuary who, on behalf of a state, is forming an opinion concerning the "actuarial soundness" of rates to be offered to MCOs and for submission to CMS.

The paragraph above uses the words "'actuarially sound' for that particular MCO." There is no federal regulatory requirement that rates are to be "actuarially sound" for a particular MCO. However, some states may require MCOs that make rate bids or that accept offered rates to provide the state with an opinion as to the "actuarial soundness" (or an opinion addressing acceptability but not using the term "actuarial soundness") of the rates for that particular MCO. An MCO may reasonably decide to accept rates for a particular year while knowing that it expects an underwriting loss in that year. Such a decision may be a reasonable business decision, given that the MCO is entering a new market or expects underwriting gains to emerge in future periods.

Regardless of the method used to arrive at a contract between a state and an MCO, an actuary advising the MCO is usually prudent to make a reasonable effort to confirm that the MCO's management understands the risks inherent in such a contract. Some states require that MCOs produce an actuarial certification that the contracted rates are sufficient but not excessive. Some states have minimum loss ratio requirements that would apply to Medicaid MCO rates. Actuarial certifications for NAIC annual statements (and quarterly statements, in some states for some MCOs) would typically require the development of deficiency reserves if the Medicaid line of business is expected to operate at a loss until the next premium rate change. Numerous ASOPs apply to the actuarial work performed on behalf of MCOs that accept risk on Medicaid and other recipients.

The remainder of this practice note describes items an actuary may wish to consider when certifying that Medicaid rates meet CMS requirements. These include items from the regulation (including the section on "Comments and Responses") as published in the Federal Register and from the rate-setting checklist. Sample certification language is also included.

9. The work group is sensitive to the issue of, on the one hand, providing a road map to understand rate development, while on the other hand, preserving practitioners' freedom to use actuarial judgment in the setting of individual assumptions. For example, Section IV, Item AA.3.2 provides a more comprehensive list of the usual considerations for expense allowance and profit/risk levels.
10. There is no prohibition on a state relying upon an MCO actuary's opinion. In some competitive bidding instances, there may be times when the state chooses to accept and submit to CMS the plan's certification.

III. The Medicaid Managed Care Regulation (including the "Comments and Responses" section)

Overview

In developing rates for capitated Medicaid managed care programs, actuaries follow the regulatory requirements stated in 42 CFR § 438.6 (c) and are normally familiar with the guidelines stated in the CMS checklist. In particular, CMS recommends that the "Comments and Responses" section preceding the main body of the regulation be reviewed, since it represents CMS's interpretation of the statutory requirements.

This section provides additional clarification of the regulatory requirements, and identifies areas where they appear to conflict with actuarial practices and principles.

Regulatory Requirements and Issues:

1. **Section 438.6(c)(4)(ii) requires that all payment rates be based only upon services covered under the state plan (or costs directly related to providing these services).**

   What are some of the issues related to this requirement? What would CMS allow, and what would actuaries usually do?

We can classify the non-state plan services into the following categories:

a. Substituted services that cannot be built into the rate calculations;
b. Substituted services that require demonstration that their equivalent value in state plan services can be included in the rate calculations;
c. Additional services that cannot be included in the rate calculations; and
d. Additional Medicaid waiver services that can be built into the rate for individuals specifically covered in the waiver (i.e., 1115 or 1915(c) waiver) or into a separate rate for individuals under a 1915(b)(3) waiver.[11]

In the "Comments and Responses" section, it is reported that there were concerns expressed regarding the rule that the state must exclude from the rate calculations any costs related to services that are not in the state plan. The "Comments and Responses" section includes a number of comments that favored the inclusion of these amounts. In general, these comments can be summarized by the statement, "MCOs must maintain the flexibility to be able to arrange for and provide whatever services most efficiently meet the needs of their members, and these alternative services may not be in the state plan." The position of CMS is that it will prevent states from obtaining federal financial participation (FFP) for things such as new b(3) services (a reference to the authorizing clause in Section 1915 of the Social Security Act) or other state-funded services, for which FFP would not ordinarily be available, by including them in an MCO, PIHP, or PAHP contract.

When discussing rates which are based on FFS data, the "Comments and Responses" section says that managed care contractors have the ability to provide services that are in the place of, or in addition to, services covered under the state plan and that these additional or alternative services do not affect the capitation rate paid to the MCO by the state.

In response to a comment about the use of encounter data for setting rates, CMS says, "actuaries must adjust the data to reflect FFS state plan services only. States cannot use … services not part of the state plan to calculate "actuarially sound" rates. We are open to suggestions from states and their actuaries, but we will not modify the basic principle that rates be based only on services covered under the state plan."

11. Actuaries are normally prudent to verify both that the data are according to waiver/contract services and that they are appropriately interpreting policy and reflecting the impact in calculated rates.

CMS indicates that it will accept a demonstration of cost efficiency for services that are delivered at the health plan's option. For example, in the substitution of sub-acute days for inpatient days, the rate development would usually convert the non-plan services to plan services on a substitution basis. This process is based on detailed encounter data permitting a comparison of the unit cost of the substituted service with the unit cost of the state plan service. This requirement to demonstrate savings may be more difficult (and perhaps impossible) to comply with if services are offered by a health plan to replace other services but are expected to decrease *future* costs, rather than current costs. Prenatal classes might be an example of this type of service. CMS acknowledges that it is important to allow health plans and states the opportunity to justify offering services that are cost efficient. However, there may be services that are offered to provide a better product to members that cannot be easily justified on a cost efficiency basis. These services may be treated as an administrative expense, classified as member services, or viewed as marketing.[12]

The reader may also wish to refer to:

(a) Discussion in Federal Register, p. 41003.
(b) Checklist section 2.4
(c) Practice note, section IV— checklist discussion on AA. 2.4

2. **Section 438.6(c)(5)(iii) specifies that contracts with incentive arrangements may not provide for payment in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement, since such total payments will not be considered "actuarially sound."**

   What are the issues and what will actuaries normally do to comply?

The requirement that the incentive arrangements may not provide for payment in excess of 105 percent of the approved cap payments is a compliance issue and, if violated, would likely result in the payments being considered by CMS as non-compliant.

3. **In the "Comments and Responses" section, there were discussions that highlight actuaries' concerns regarding "actuarial soundness" — specifically, rate adequacy vs. methodology and process.**

   How is rate adequacy normally addressed?

Rate adequacy is a component of "actuarial soundness."

State rate filings have frequently required an actuarial opinion stating that "the rates are not inadequate, excessive, or unfairly discriminatory." However, the actuary stating the opinion is normally hired by the company filing the rates, either as an employee or as a consultant, and usually has access to the data, assumptions, business plans, etc. that support those rates.

Rate adequacy for Medicaid would normally mean that rates calculated and paid by a state Medicaid agency are likely to cover the costs of the program. The actuary working for the state may only have access to publicly available financial information about the health plans that contract with the state.

12. These non-state plan services may also be covered under a b(3) waiver if the state had previously received one. These waivers were to provide FFP for non-state plan services that were paid for using savings realized in moving to managed Medicaid. However, CMS has taken the position that there will be no new b(3) waivers approved. Existing b(3) waivers have been grandfathered effective August 2003; however, CMS has stated that no new non-state plan services can be added, and that the average increase in costs for the b(3) services cannot exceed the average increases in costs for the state plan services.

It is generally difficult to set any specific administrative targets, either in percentage of capitation or amount per member per month (PMPM), without knowledge of the specific environment in each state – including such items as populations covered, services covered, medical costs, access to health care, and other factors.

The same concept applies to profit/risk levels. It is generally difficult to specify a precise value, and this practice note makes no attempt to do so. However, there would usually be appropriate profit/risk margins included in the capitation rates.

Provider reimbursement and medical management are also usually difficult for an outside observer to predict. Thus, the actuary may choose to make estimates based on what is publicly known about the level of Medicaid managed care in a specific state. The actuary may be able to reasonably estimate the level of management of health care from the encounter data.

The discussions on pp. 40998 and 41001 of the Federal Register contain information relevant to this issue.

4. **In the "Comments and Responses" section, the question is raised whether states will have the flexibility to take into account their FFS budgets, and managed care budget authority, when developing "actuarially sound" rates.**

   How would the actuary usually address this?

"Actuarially sound" rates or ranges of rates depend on the benefits provided and the population covered. These rates are normally independent of budget issues unless benefits or populations change.

In times of economic downturn, state budgets may exert pressure on rates that must be certified as "actuarially sound." This pressure can build as program expenditures are capped, yet "actuarially sound" rates are usually independently determined. In rate-setting, there is normally a range of reasonable assumptions. Budgetary constraints may influence the selection of certain assumptions toward the low end of the range. However, the actuary would usually be prudent to select assumptions that are individually reasonable and appropriate when deriving the final premium rates.

5. **Does the regulation require each rate cell to be "actuarially sound?"**

Section 438.6(c)(2) requires "all payments" to be "actuarially sound." Pages 40998–40999 of the "Comments and Response" section specifically state that "all payments" refers to individual rate cells. CMS appears to be looking for the certification of "actuarial soundness" to apply to each individual rate cell.

CMS also specifies requirements concerning the establishment of rate cells. Section 438.6(c)(3)(iii) requires states to establish rate cells by eligibility category, age, gender, region and risk adjustment (or explain why any of these factors is not applicable). Section AA.4.0 of the checklist indicates that the key principle is that rate cells should be developed *"whenever the average* [which we interpret as "expected"] *costs of a group of beneficiaries greatly differ from another group and that group can be easily identified."*

CMS expects that rates will usually be developed for appropriate rate cells, taking into account the credibility of the data for each rate cell. Where sufficient data are unavailable to establish a rate for a particular cell, the rate would normally be developed based on blended data from that cell and an adjacent cell. Further, separate rate cells would usually be established only where there is a meaningful difference in expected per capita costs.

6. **Section 438.6(c)(5)(ii) specifies that, if risk corridor arrangements result in payments that exceed the approved capitation rates, these excess payments *will not be considered "actuarially sound"* if they result in total payments that exceed the amount Medicaid would have paid, on a fee-for-service basis, for the state plan services actually furnished to enrolled individuals.**

   What are the issues related to this requirement, and what would actuaries normally do?

This requirement is a compliance issue and, if violated, would likely result in the payments being unable to be determined as "actuarially sound."

State payments under risk corridor arrangements in excess of those permitted by CMS do not meet regulatory requirements. Since the contracts involved put the MCO at risk, CMS has determined that a limit on total payments should be established. Therefore, in developing both base rates and risk corridors, the actuary would usually consider the potential range of variation in experience that may emerge, so that in the aggregate the contractual arrangement meets the regulatory requirement under likely scenarios.[13]

13. In situations where there is little or no data on which to base rates, and risk corridors are being used, discussions with CMS may be appropriate to support compliance.

IV. CMS Rate-setting Checklist

CMS provides materials for regional offices to utilize in reviewing and approving contracts and capitation rates associated with Medicaid managed care programs. One of these tools is a checklist to be used by the regional offices in reviewing and approving the rates under 42 CFR 438.6(c) for all Medicaid managed care programs, excluding the PACE capitated programs. An actuary preparing capitation rates for use in Medicaid managed care programs would usually review and become familiar with the most recent version of the checklist. This section of the practice note provides a general overview of the checklist, as well as an outline of areas of the checklist that may have a potential for misinterpretation or may be counter to generally accepted actuarial practice. The comments prepared in this section relate to the checklist entitled "Appendix A. PAHP, PIHP, and MCO Contracts, Financial Review Documentation for At-risk Capitated Contracts Ratesetting, Edit Date: 7/22/03."

Overview

The checklist was developed by a CMS work group that had previously been involved in the development and/or review of capitation rates for managed care programs. Based on its own experience, as well as the regulatory requirements of 42 CFR 438.6(c), the work group prepared the checklist document to assist the regional offices in reviewing the materials prepared and submitted by the states and their consulting actuaries in support of their proposed Medicaid managed care capitation rates.

The checklist has been separated into seven primary sections. The rate-setting actuary would usually review the checklist document to become broadly familiar with each of these items. In reviewing the checklist, the rate-setting actuary may find it helpful to recognize that some of the items outlined may not be found in the rate-setting methodology that was used. Several of the items that are identified in the checklist relate to contractual or state regulation. The actuary may want to discuss these items with state Medicaid personnel to identify any likely impact on the rate-setting methodology. The following provides a brief description and overview of each section.

AA.1.0 — *Overview of Rate-setting Methodology*. This section requires documentation regarding the general rate-setting methodology and contract procurement and the actuarial certification. Under the contract procurement section, two methodologies are outlined: open cooperative contracting and competitive procurement. Under the open cooperative contracting methodology, the actuary may establish a single rate for each rate cell the state would use in contracting with the MCOs. Under the competitive procurement methodology, the actuary may establish a range of rates for each rate cell.[14] The actuary's range of rates would normally be used as a guide for either contract negotiations by the state or for submission of bids by the MCOs. A sample of an actuarial certification has been provided in Section VI of this practice note.

AA.2.0 — *Base Year Utilization and Cost Data*. This section outlines the types of data and information that may be used in the establishment of the capitation rate. The checklist indicates that the base year utilization and cost data should be consistent with the Medicaid services and population that will be covered by the contract. With respect to the Medicaid population selection, the actuary would normally become familiar with the different populations that are included or excluded from the MCO contract, including dual-eligibles and spend-down recipients. The checklist allows for the use of Medicaid FFS data, Medicaid managed care data, or non-Medicaid data. The checklist describes the types of services that may be used in the analysis. The checklist provides a description of the requirement for inclusion of state plan services only and possible allowances for additional services.

14. CMS has received some rate ranges based upon "Degree of Health Care Management" whereby the actuary assumed a higher or lower level of "care management" to develop the rates. CMS usually expects to see justification as to why the state or actuary expects a range of rates to be appropriate (e.g., inflation, trend, utilization variances).

AA.3.0 — *Adjustments to the Base-Year Data*. The section outlines the types of adjustments that would be allowed on the base-year data to develop the capitation rates. The checklist provides a listing of many items concerning which the actuary would usually exercise professional judgment to determine the appropriateness of the adjustment based on the underlying base-year data chosen. This section of the checklist illustrates the desirability of a movement from the prior upper payment limit rate-setting calculation methodology to the development of a capitation rate that would be "actuarially sound." For example, the factors reflect adjustments to reimbursement per unit of service,[15] utilization rates, and contractual obligation or benefit differentials so that the rates are "actuarially sound" for the covered Medicaid population. The rate-setting actuary is challenged to develop a rate that would be "actuarially sound" for a third-party entity. Usually, each of the adjustments would be carefully reviewed for applicability. The outlined adjustments typically include one for the review of the financial experience of the health plans. The rate-setting actuary would normally be familiar with the process of reviewing financial statements and interpreting the results.

AA.4.0 — *Establish Rate Category Groupings*. This section of the checklist outlines different rate-setting categories that would normally be considered in the establishment of the capitation rates. The rate-setting categories include age, gender, locality/region, and eligibility categories. The checklist indicates that each of these components would normally be used in establishing rate-setting categories, unless omitting a component or combining a rate category with an adjacent category can be justified.

AA.5.0 – *Data Smoothing, Special Populations, and Catastrophic Claims*. This section of the checklist outlines methodologies that may be used in the examination and modification of the data to reflect any data distortions or special populations. The checklist indicates that it is usually preferable for the data smoothing techniques to be cost-neutral. The checklist provides a brief definition of cost-neutrality for the actuary to review. This section also briefly discusses the use of health status-based (or diagnosis-based) risk adjustment.

AA.6.0. — *Stop Loss, Reinsurance, or Risk sharing Arrangements*. This section of the checklist includes an outline of the use of reinsurance, either commercial or state-sponsored, in the determination of the capitation rate. The regulations call for inclusion of these provisions to be determined on an "actuarially sound" basis. The risk corridor limit compares total payments to MCO state plan services provided, priced at the Medicaid FFS fee schedule, plus an amount for MCO administrative costs. A risk corridor or risk sharing mechanism may involve the actuary comparing the cost of the managed care program to a FFS program before receiving approval from CMS for the inclusion of a risk corridor program. The checklist discusses the inclusion of a risk corridor program and provides an example.

AA.7.0 — *Incentive Arrangements*. This section of the checklist outlines the use of incentive arrangements in the contract between the state and the MCO. An incentive arrangement provides additional funds in excess of the capitation rates for meeting specified targets. The checklist states that the incentive arrangement payment may not increase total payments above 105 percent of the approved capitation rates. Additionally, all incentives are expected to be determined through the use of an "actuarially sound" methodology.

Considerations in Complying with the Checklist

This section of the practice note discusses items that may be considered by the rate-setting actuary when developing the capitation rates and complying with the checklist. The checklist is a general document and probably does not cover every circumstance the actuary may encounter. Should the actuary think it appropriate to deviate from the guidance provided in the checklist, he or she would usually be prudent to describe and explain the deviation.

15. One commenter noted that "adjustments to reimbursement per unit of service" for the impact of intergovernmental transfers have been particularly problematic in the development of rates.

Section AA.2.0 — *Base-Year Utilization and Cost Data*. This section states, "States without recent FFS history and no validated encounter data will need to develop other data sources for this purpose. States and their actuaries will have to decide which source of data to use for this purpose, based on which source is determined to have the highest degree of reliability, subject to RO approval."

Comment: The actuary should consider ASOP #23 (Data Quality) in the development of the base-year data. Generally, the actuary would consider all available data, including the Medicaid FFS data, Medicaid managed care encounter data, Medicaid managed care financial reports and Medicaid MCO financial statements. The actuary typically would compare data sources for reasonableness and check for material differences when determining the preferred source(s) for the base-period data.

The checklist refers to several data sources CMS would consider appropriate. The actuary typically would consider these data sources as well as the most recent available data that, in the actuary's professional judgment, appear to be reliable and well-suited to the assignment. The checklist acknowledges that there are instances where the commonly used data sources are unavailable.

Section AA.2.4 — *State Plan Services Only.* This section states, "The state must document that the actuarially sound capitation rates are appropriate for the services to be furnished under the contract and based only upon services covered under the state plan." Additionally, "Services provided by the managed care plan that exceed the services covered in the Medicaid state plan may not be used to set capitated Medicaid managed care rates."

Comment: The actuary may want to remove the value of non-state plan services and add in the value of any significant state-plan services that are not reflected in the data. Additionally, as FFS data erodes, data and information for developing the amount of the adjustment for substituted services may not be available.[16]

AA.3.0. — *Adjustments to Base-Year Data.* This section states, "The state made adjustments to the base period to construct rates to reflect populations and services covered during the contract period. These adjustments ensure that the rates are predictable for the covered Medicaid population."

This section includes adjustments that are more specific to the Medicaid rate-setting process than the rate-setting actuary will normally have encountered in the commercial or Medicare managed care environments. The rate-setting actuary is usually prudent to understand each of these adjustments and discuss these items with state Medicaid personnel as necessary. Additional comments related to the other adjustments are as follows.[17]

Pharmacy rebates – State Medicaid programs, which participate in the federal drug rebate program, receive additional rebates for prescribed medications. The rebates are generally greater than rebates received by managed care organizations through their prescription drug contracts.

Managed care adjustment – This adjustment may have a significant impact on the development of the capitation rate or rate ranges. The adjustment may be developed based on the reported experience of managed care organizations, be it publicly available or commercially available information. The managed care adjustments will usually affect both utilization rates and unit costs

16. Capitation rates may be based only on Medicaid state plan services to Medicaid covered eligibles, so an actuary would initially remove the value of non-state plan services. The actuary is usually careful to not reincorporate the value of these excluded services.
17. One commenter mentioned that managed care adjustment (initial or update) assumptions may also result from encounter data analysis benchmarking, or on-site operational reviews measuring the medical utilization and cost management effectiveness of the MCO(s). Assumptions could also be derived from state and/or MCO expectation of continuous improvement in the MCO's medical utilization and cost management.

Financial experience adjustment –This adjustment is most often used for a rate update approach, rather than a rate re-basing approach. These adjustments would usually arise only when calculating future rates based on prior rates.

AA.3.2. — *Administrative Cost Allowance Calculation*. This section says that the state must document that the rate was adjusted to account for MCO, PIHP, or PAHP administration.

In determining an appropriate level of an administrative cost allowance, the rate-setting actuary may want to consider the following items:

- Overall size across all lines of business
- Lines of business covered by the capitation
- Age of the health plan or years of participation in Medicaid
- Organizational structure
- Demographic mix of enrollees
- Marketing expenditures
- Claims processing expenditures
- Medical management expenditures
- Staff overhead expenses
- Member services
- Interpreter services

The section further notes, "CMS does not have established standards for risk and profit levels but does allow reasonable amounts for risk and profit to be included in capitated rates."

Comment: In the determination of an appropriate level of a profit and risk allowance, the rate-setting actuary may want to consider the following items:[18]

- Contingency margin
- Contribution to surplus
- Investment rate of return
- Profit margin

AA 3.7 — *Copayments, Coinsurance, and Deductibles in Capitated Rates.* This section says, "If the state uses FFS data as the base data to set rates and the state Medicaid agency chooses to not impose the FFS cost-sharing in its pre-paid capitation contracts with entities, the state must calculate the capitated payments to the organization as if those cost-sharing charges were collected."

Comment: When determining the appropriate adjustment for copayment amounts, an actuary considers an appropriate adjustment for a collection percentage associated with the copayment amounts.

AA.3.10 — *Medical Cost/Trend Inflation*. This section states, "Medical cost and utilization trend inflation factors are based on historical medical state-specific costs or a national/regional medical market basket applicable to the state and population. All trend factors and assumptions are explained and documented."

18. It may be appropriate for the actuary to consider the public nature of the venture (e.g., government owned PIHPs). Governmental entities without competitive procurement may not be permitted to have contribution to surplus, investment rate of return, or profit margin because this contributes to the federal Medicaid budget subsidiary programs not under Title XIX. Refer to OMB-A87 and 1903(i)(17) of the SSA. The actuary is usually prudent to have considered all relevant factors in selecting an appropriate level of profit and risk allowance.

Comment: The actuary may choose to consider a number of elements in establishing both utilization and unit cost trend rates. Utilization trend rates typically will be affected by changes in demographics, medical technology, benefit levels, and the degree and emphasis of medical management. Unit cost trends may be affected by changes in state-mandated fee schedules (if applicable), FFS cost levels, and provider contracting performed by the health plans. The contracted rates between the MCO and providers are potentially the most variable, by plan and by local market, and least likely to be known by the state's actuary. Therefore, a range of estimates may be more appropriate in accordance with the actuary's professional judgment. However, the rate-setting actuary may be requested to establish a single-point estimate for a cost trend.

Projection of future results through the projection of trend rates typically requires the most flexibility and judgment of any part of the rate analysis. Historical results from FFS or other data sources would normally be considered but not fully relied upon, because the mix of providers and services and the market landscape may have changed. In particular, FFS data may have deteriorated or may not apply in heavily managed care environments. Depending on the timing and impact of managed care implementation— and on market penetration and growth — increasing, flat, or decreasing trends may occur. Local market conditions are generally more important, but harder to determine, than statewide or nationwide trends.

Section AA.3.12 – Utilization and Cost Assumptions – This section states, "The State must document that the utilization and cost data assumptions for voluntary programs were analyzed and adjusted to ensure they are appropriate for populations to be covered if a healthier or sicker population voluntarily chooses to enroll."

Comment: The rate-setting actuary would normally consider the data used to develop the adjustment. If encounter data from the MCOs were used, the population may have shifted from the time of the base period to the time of the rate period. If some other base was used, the rate-setting actuary would usually verify that the adjustment appears to be appropriate. Examples of such adjustments would be those for a program change or expansion in the covered population.[19]

AA.5.2 – Cost-neutral data smoothing adjustment – This section states, "If the State determines that a small number of catastrophic claims are distorting the per capita costs then at least one of the following cost-neutral data smoothing techniques must be made."

Comment: The cost-neutral data smoothing techniques outlined call for the rate-setting actuary to balance the potential for adverse selection with the actual risk assumed by the managed care organizations. The checklist defines "cost neutral" as a process that results in no aggregate gain or loss across all payments categories. The rate-setting actuary may wish to select an appropriate methodology for pooling large claims or the inclusion of reinsurance.

AA.5.3 – Risk Adjustment – This section discusses the optional use of risk adjustment based upon enrollees' health status or diagnosis and requires that the risk adjustment be cost neutral.

Comment: The rate-setting actuary is usually prudent to be broadly familiar with the theory and statistical success as well as the inherent strengths and weaknesses of the risk adjustment model the state employs. Background materials on such models are frequently available through the Society of Actuaries and the American Academy of Actuaries, including several reports that outline the statistical characteristics of the models.

19. It is normally appropriate to include an analysis of whether or not the population covered under the contract has a different acuity than the data being used to set the rates.

The diagnosis-based risk adjustment methodologies generally utilize statistical models based on historical FFS or managed care base data. The reliance on diagnosis-specific data may be hindered by the capitation contracts that are often encountered in managed care programs. The capitation contracts may result in underreporting of encounter data to the managed care organization, and subsequently to the state Medicaid encounter system. The underreporting will usually result in a lower morbidity score than what might result from a review of all claims.

The rate-setting actuary would typically consider the adjustment technique that will be utilized in the rate-setting process. The diagnosis-based risk adjustment methods may be implemented using either concurrent or prospective adjustments. The actuary would usually consider the criteria for evaluating a risk adjustment mechanism that are identified by the Society of Actuaries and the American Academy of Actuaries in the reports mentioned above.

AA.7.0 – Incentive Arrangements – This section states, "CMS will not consider payment rates to be actuarially sound if incentive arrangements provide for payment in excess of 105 percent of the approved capitation rate payments attributable to the enrollees or services covered by the incentive arrangements…"

Comment: The requirement that the incentive arrangements may not provide for payment in excess of 105 percent of the approved capitation payments is a compliance issue, and if violated, would normally result in the payments being unable to be determined as "actuarially sound."

In determining an "actuarially sound" incentive, the actuary would normally consider the specific criteria associated with utilization targets established within the terms of the contract. The amount of the incentive would usually reflect the cost of providing the services specified in the incentive clause. For example, if there is an incentive payment associated with increasing the number of members receiving physical examinations, then the incentive payment typically would be based in part on the cost of providing the additional physicals.

The checklist is not clear if the 5 percent limitation is by rate cell or in total. As an illustration, in the example of providing physical examinations to adults, it is unclear if this particular incentive payment is limited to 5 percent of the adult capitation payments, or if it is only the sum of all incentive payments that is limited to 5 percent of the total capitation payment made to the health plan.

V. Documentation

This section provides an overview of documentation for Medicaid managed care rate development.[20] The actuary usually develops documentation in support of the actuarial work product. The extent of the documentation is normally appropriate to the circumstances for which the rates are developed. These items are indicated on the checklist. The documentation typically describes the relevant data, sources of data, material assumptions, methods and process by which the rates were developed with sufficient clarity that another qualified actuary practicing in the same field could make an objective evaluation of the reasonableness of the work product. Note that, for an actuary working on behalf of a state Medicaid agency, the regulation does not require that the documentation be shared with any party – such as a participating MCO – other than the actuary's client (i.e., the state).

The actuary normally explains the reason(s) for and describes the effect of any material changes in sources of data, assumptions or methods from the last analysis.[21]

Generally speaking, there are four key areas to be documented:

A. Data integrity

B. Experience period data

    1. Items related to claims data

    2. Items related to administrative cost allowance

C. Trend factors

D. Risk

The extent of the documentation would usually be, at a minimum, the level required in the checklist. The required documentation identified in the checklist includes the source(s) of data, material assumptions, the methods used, and the process by which the rates were developed. The actuary would usually explain the reason(s) for and describe the effect of any material changes in the source(s) of data, assumptions, or methods from the last rate-setting.

20. The documentation would usually include, at a minimum, the following five elements: 1) The state submits the actuarial certification for the final rates to be paid to the contractors; 2) Rates may be based only on Medicaid services; 3) Rates may only pay for services to Medicaid beneficiaries; 4) The state submits an expenditure projection comparing previous and proposed rates; and 5) The State explains any incentives or risk-sharing. Additional guidance on documentation may also be obtained from ASOP No. 31. Actuaries can appropriately prepare by examining approved Medicaid State Plans, waivers and contracts in order to understand the Medicaid services and Medicaid beneficiaries that are to be covered in the rates.

21. The documentation would usually be available to the actuary. The sharing of documentation is generally under the control of the actuary's client.

A. Documentation of Data Integrity.[22] The actuary normally documents how the following issues are addressed in the ratemaking process, to the extent that they are relevant and material:

- Choice of experience period
- Choice of experience data
- Credibility/validation of data
- Adjustments and use of external data

1. Experience Period: For documentation purposes, an explanation of the basis by which the experience period was selected would usually be provided. For Medicaid ratemaking projects, the fiscal calendar may dictate the basic parameters of the project. The experience period will usually be selected to be the most recent, with sufficient time for reasonable runout to allow the rates to be determined in the fiscal process. If a different experience period than is normally used in the fiscal process is used, its use would typically be disclosed and explained.

2. Experience Data: Documentation would usually be provided so that only State Plan approved services that are the responsibility of the managed care organization are included in the base data (AA.2.4). A data book accompanies many managed Medicaid ratemaking projects. The data book typically provides a summary of the base data, often in sufficient detail to calculate experience period PMPM rates by rate cell.

3. Credibility/Validity: The methods and procedures used to validate the data would normally be documented.

4. Adjustments Made/Use of External Data: The source and relevance of any adjustments made or external data used in "completing" or enhancing the base data would usually be provided.

B. Documentation of the Development of Experience Period Costs. The actuary would usually document how the following issues are addressed in the ratemaking process, to the extent that they are relevant and material:

- Calculation of exposure units
- Adjustments to experience data
- Policy and provider contract provisions
- Mix of Business [23]

1. Items related to claims data

The majority of the discussion in the previous section was on claims experience, its analysis, use, and modification (or adjustment). The current section begins to make refinements to the claims data, to begin to put it in a framework of developing rates. The claims experience will generally be divided by exposure units. This step presumes an appropriate mechanism has been developed to establish rate category groupings.

22. CMS requires base utilization and cost data from a Medicaid population or similar population adjusted to reflect only Medicaid services and eligibles. CMS further requires actuaries to use actual databases instead of samples to create the base data.
23. As the actuary examines splits of eligibles by demographic category, it might be determined that a mix of business adjustment would be beneficial between two rate cells due to shifts in exposure and cost.

- Exposure Units: This step is intended to encompass several items. The rate category groupings used would normally be documented, especially if there is a change from the prior structure. If specific population sub-groupings are expected to undergo special changes (due to program changes, redefinitions, or anticipated economic shifts), the actuary may choose to disclose how these factors adjusted the expected results. Documentation would usually include a description of the impact of retroactivity and plans' contractual responsibilities, when appropriate. Adjustments made to ensure that exposures are consistent with accepted base experience data (e.g., if a plan's encounter data were removed because they were considered invalid, also remove exposures) would also usually be documented (AA.3.4).

- Adjustments to Experience Data: To the extent adjustments differ between rate cells, documentation would normally reflect the differences.

- Operational/Benefit Changes: If an operational change is expected to impact the ratemaking, it would usually be described. Examples might include carving out a formerly covered service, or bringing a formerly carved out service back into the at-risk rates. A new type of service might be added or removed from covered services since the base year. An explanation of the change and its impact would usually be provided (AA.3.1).

- Investment Income: To the extent new benefits or new population groupings are added to the managed care program, or carved-out services are added back, there might be a lag in claims versus funding and an adjustment for investment income might be appropriate. An investment income adjustment can also be used when using FFS data. If used, disclosure and documentation are normally provided.

- Special populations adjustments: The checklist states that this adjustment can only be made if the population has changed since the base period experience data. If this occurs, an explanation of the adjustment would usually be provided (AA.3.3).

- The actuary usually discloses whether any DSH payments are included in the rates (AA.3.5); typically they are not.

- With respect to third-party liability, the actuary normally explains the TPL arrangement and documents any significant adjustments (AA.3.6).

- Policy and Provider Contract Provisions: To the extent that deductible, coinsurance, copays, coverage limitations and coordination of benefits impact the Medicaid managed care population or expanded populations, it may be appropriate to model policy and contract provisions against available data and their documented impact (AA.3.7). The Medicaid checklist discusses incentive arrangements, and requires the parameters of the program and its impact to be documented (AA.7.0).

- With respect to graduate medical education (GME), the actuary usually documents any material adjustments (AA.3.8).[24]

- With respect to FQHC/RHC, the actuary usually document any material adjustments (AA.3.9).[25]

- Smoothing/Large Claims (Shock Loss Claims): The effect of large claims, including the effect

24. States may pay GME outside of capitation rates only if these payments are excluded from the capitation rate and are not more than they would have been under FFS.
25. CMS has specific requirements that the actuary usually considers in the documentation of the appropriate treatment of services rendered by FQHC/RHCs.

of large claims on the experience period data and on the projection of historical data to the rating period, and how the cost of large claims is incorporated in the ratemaking process would normally be documented. The effect of reinsurance arrangements is often related to the discussion on large claims.

Smoothing can be used to reduce distortions in the data caused by a few large claims. The checklist requires smoothing to be cost-neutral. Documentation on the technique used would usually be provided.

- Any additional material adjustments would normally be explained.

2. Items related to expense allowance

- Administrative Expenses: Expenses are usually an important part of the development of rates. In general terms, expenses are sometimes referred to as retention. Retention includes expenses, as well as risk charges (possibly for pooling or other contingencies), the cost of capital and the ability to support reserves (and capital) needs with a contribution to surplus. Assumptions used to adjust for each of these factors would normally be documented. (AA.3.2)

- The documentation may address the treatment of other items of retention, including all provision for risk charges and the cost of capital and the ability to support reserves with a contribution to surplus.[26]

C. Documentation of Trending Factors. The actuary would typically document how the following issues are addressed in the ratemaking process, to the extent that they are relevant and material:

- Trend Measurement

- Claim Cost Trend Factors

- Other Trend Factors

The documentation of trend and its measurement and application can be a critical area to understand. The report would usually include a comparison of last year's trended rates to this year's estimates.

- Trend Measurement and Trend Selection: The method of developing cost and utilization trend factors would usually be documented in appropriate detail.

- Claim Cost Trend Factors: The factors affecting the change in claim costs over time would typically be discussed. Unless otherwise accounted for, these factors usually include, but are not limited to: general price inflation, leveraging, changes in provider contract, medical cost inflation, changes in medical practice, demographics, changes in policy provisions, and utilization.

- Other Trend Factors: The factors affecting the change of other ratemaking parameters over time would normally be disclosed.

D. Issues Related to Documentation of Risk. The actuary would normally document how the following issues are addressed in the ratemaking process, to the extent that they are relevant and material:

- Risk Provision: In an at-risk ratemaking process, there is typically an expectation that a participant should have a reasonable probability of achieving target-operating margins. The target-operating

26. Risk charges are also addressed in Section D, Issues Related to Documentation of Risk.

margin would usually be disclosed. If the target-operating margin is 0 percent for the entire system, one scenario is that 50 percent of the participants will exceed the target and 50 percent will not. In this simple example, for plans to achieve target-operating margins, the operation of the plans as a whole would usually be expected to achieve a more efficient delivery of care than the assumptions suggest. Many actuaries prefer the target-operating margin to be positive (i.e., rather than be 0 percent). They believe that this level of target margin would normally be achievable by a health plan operating in an efficient manner within the program guidelines.

- Stop Loss, Reinsurance, or other Risk Sharing: Rates would normally be adjusted to reflect the risk the State is willing to assume. Documentation on the effect to the rates would usually be provided. This risk factor is covered in Subsection 6.0 of the checklist.

- External Influences: This factor appears to describe the pressures that might be affecting state budgets. Refer to Section III, Item 4 of this draft, for guidance on this issue. Other external influences may come to the actuary's attention. Since these circumstances will most likely not have an existing body of knowledge or data available, discussion with CMS early in the process is recommended in most instances.

- Risk Classification Plan: The issue of risk classification is directly covered in the checklist at Subsection AA.5.3 The documentation would usually include:

    - An explanation of the risk assessment methodology chosen

    - Documentation on how payments will be adjusted

    - Demonstration of cost neutrality

    - Procedures for monitoring and re-basing

Conclusion

Normally, the actuary's documentation would address the reasonableness or appropriateness of the assumptions and methodology used in the ratemaking process. The chosen data, assumptions used, and adjustments made would usually be provided. The size and effect of any significant adjustments would usually be included, as well as a statement to the effect that the adjustments are mutually exclusive and are not being applied more than once if such a statement is accurate.

VI. Certification Language[27]

Sample Certification Language
State of XXXXX
Actuarial Certification

I, {your name}, am an employee of the Division of Medical Services of the State of XXXXX. {If a consulting actuary, the actuary would usually indicate the company affiliation.} I am a Member of the American Academy of Actuaries {mandatory} and an Associate / Fellow of the Society of Actuaries {if applicable}. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established from time-to-time by the Actuarial Standards Board. I have been employed {either as an employee or as a consultant} by the State of XXXXX for the past YY years and am generally familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions.

The capitation rates provided with this certification are considered "actuarially sound" for purposes of 42 CFR 438.6(c), according to the following criteria:

- the capitation rates have been developed in accordance with generally accepted actuarial principles and practices;
- the capitation rates are appropriate for the Medicaid populations to be covered, and Medicaid services to be furnished under the contract; and,
- the capitation rates meet the requirements of 42 CFR 438.6(c).

The assumptions used in the development of the "actuarially sound" capitation rates have been documented in my correspondence with {either the state or the MCO}. The "actuarially sound" capitation rates / rate ranges that are associated with this certification are effective for the YY month period beginning July 1, 200X.

The "actuarially sound" capitation rates are based on a projection of future events. It may be expected that actual experience will vary from the experience assumed in the rates.

In developing the "actuarially sound" capitation rates, I have relied upon data and information provided by the State. I have relied upon the State for audit of the data. However, I did review the data for reasonableness and consistency (if applicable).

The capitation rates developed may not be appropriate for any specific health plan. An individual health plan will need to review the rates in relation to the benefits that it will be obligated to provide. The health plan should evaluate the rates in the context of its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with the State. The health plan may require rates above, equal to, or below the "actuarially sound" capitation rates that are associated with this certification.

_____ _____

John Q. Smith Date
Member, American Academy of Actuaries

27. This sample certification language is offered solely for educational purposes and is not intended to limit in any way the content of individual actuaries' certifications. The actuary is encouraged to develop appropriate language for each certification, and is under no obligation to make use of the sample language offered here.

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