Title of Exposure Draft: Medicaid Managed Care Capitation Rates

Comment Deadline: September 1, 2026

Instructions: Please review the exposure draft, and give the ASB the benefit or your recommendations by completing this comment template. Please fill out the tables within the section below, adding rows as necessary. Sample for completing the template provided at the following link:

Each completed comment template received by the comment deadline will receive consideration by the drafting committee and the ASB. The ASB accepts comments by email. Please send to comments@actuary.org and include the phrase 'ASB COMMENTS' in the subject line. Please note: Any email not containing this exact phrase in the subject line will be deleted by our system's spam filter.

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

Restating comments verbatim or with slight variations may slow down the ASB review process. If you wish to reinforce any comments provided in another commentator's submission, please clearly state how your comments agree or differ.

I. Identification:

American Academy of Actuaries
Annette V James, MAAA, FSA, FCA Vice President, Health, American Academy of Actuaries, on behalf of the Health Practice Council

II. ASB Questions (If Any). Responses to any transmittal memorandum questions should be entered below.

Question No.	Commentator Response
Is the guidance clear regarding what the actuary should do when the mandated capitation or revenue minimums, maximums, increases, or decreases (see section 3.3) can or cannot be achieved through the appropriate actuarial adjustments (see section 3.2)?	We do not believe the guidance is clear as written. It would be helpful if more examples were provided. For example, in 3.2, it would be helpful to offer additional clarification and examples of how the actuary should proceed if the actuary cannot certify capitation rates that meet the budget requirements using actuarially sound assumptions. In 3.3, we wonder if "appropriateness" is the best word? It seems 3.3 is trying to say that if the actuary cannot develop actuarially sound capitation rates that also meet budget restraints or other mandates, then the actuary cannot certify the capitation rates as being actuarially sound. Additional clarification would be appreciated, if that is the intent. If not, we would request the intent behind 3.3 is clearly and directly stated.
The existing ASOP No. 49 predated the initial implementation of the 2016 Medicaid Managed Care Final Rule. Significant portions of the ASOP were subsequently codified in the federal regulations (currently 42 CFR 438). Does the exposure draft appropriately minimize duplication with federal regulations while retaining sufficient guidance and clarity?	Yes.
The language in section 3.2.6 regarding state directed payments was generalized to meet current federal nomenclature and	It would be useful to clarify how payments made outside of or in addition to the capitation rates are impacted by this ASOP. If they are not part of the member level capitation rates, do they fall under the

broadened to clarify inclusion of all types of special payments. Is the guidance clear and appropriate?	purview of this ASOP? Do the actuarial soundness requirements of this ASOP apply to these payments made outside of or in addition to the capitation rates? For the same sentence, should "include" be "consider?" Also, we suggest changing "state requirements" to "state and/or federal requirements." Finally, we suggest adding some examples of non-risk based special payments, such as high-cost drugs and vaccines, as the term "non-risk based" can be confusing or potentially misleading.
Specific guidance related to mid-rating period changes for programmatic items or entering/existing MCOs was considered for inclusion in the exposure draft but ultimately deemed too specific. Is this conclusion accurate?	It would be useful to have specific guidance related to mid-rating period changes for programmatic items that address items such as how emerging experience can be included and if it's acceptable to certify just the programmatic changes or if the total rates are required to be certified. For example, if a new benefit is being included with a mid-rating period change, is the actuary certifying just the change in expense for the new benefit, or is the prior capitation rate plus the new program change being re-certified together? Does the actuary have an obligation to consider newer data and update the originally certified rate, and does that conflict with the prospective nature of the rate?

III. Specific Recommendations:

Section # (e.g. 3.2.a)	Commentator Recommendation (Please provide recommended wording for any suggested changes)	Commentator Rationale (Support for the recommendation)
Section 1.2.d	...reviewing or opining on behalf of an MCO or MCOs; and...	Expand the scope for cases of an Actuary representing more than one MCO.
Section 1.2 (Cont.)	Modify wording in last paragraph by removing the first sentence as follows: ~~If a conflict exists between this standard and applicable law (statutes, regulations, and other legally binding authority), the actuary should comply with applicable law.~~ If the actuary departs from the guidance set forth in this standard in order to comply with applicable law, or for any other reason the actuary deems appropriate, the actuary should refer to section 4.	Streamline by removing the first sentence, as this idea is already covered by ASOP No. 1
Section 2.1	Actuarially Sound/Actuarial Soundness--Medicaid managed care capitation rates or rate ranges are actuarially sound if, when taken together…	Federal regulation (42 CFR 438.4) allows the actuary to certify point-estimate contracted rates or rate ranges.
Section 2.5	In-Lieu-of Services—Benefits for services or settings approved as optional cost-effective substitutes to **state plan services**.	"In-Lieu of Services" are required to be cost-effective.
Section 2.6	....prepaid inpatient health plans ("PIHPs") and prepaid ambulatory health plans	Revised to be consistent with federal regulation syntax.

	("PAHPs").	
Section 2.7	MCO Actuary—An actuary providing actuarial services for an MCO or MCOs	Expand the scope for cases of an Actuary representing more than one MCO.
Section 2.9	Remove "RC: Spell out first use, add acronym in parenthesis and unbold throughout"	Appears an editorial comment was left in the published draft.
Section 2.11	that may be related to quality or other ~~operational~~ metrics	"Other" acknowledges that not all metrics used may be quality related and there could be types beyond "operational."
Section 2.15	Centers for Medicare & ~~and~~ Medicaid Services (CMS)	To be consistent with official name
Section 3.2.5	In first sentence, remove the word "generally": "...should ~~generally~~... "	This should be done to the extent possible, as it leaves the meaning of the sentence stronger than when "generally" is used.
Section 3.2.9c	Change to: "...during ~~in~~ the rating period."	We believe this wording is clearer.
Section 3.2.10	Change to: "...separated by utilization, unit costs, and service mix, ~~if~~ as applicable,..."	We believe this wording is clearer and supports the intent.
Section 3.2.11	Change to: "...that are reasonably attainable, based on industry experience and/or other reliable sources, during the rating period."	Make clear that "reasonably attainable" is supported by appropriate sources.
Section 3.2.12	Make f. – "provider payments made outside of the MCO claim adjudication system" – the first bullet (a.).	Bullet f describes the vast majority of these payments and should be first.
Section 3.2.13	In the last section that begins, "When determining the provision for administrative expenses...", add "e. new regulatory requirements that increase operational costs."	New requirements requiring additional operational costs for MCOs should be included
Section 3.5	Add wording: "...should notify the principal and discuss appropriate actions if, ...	Make clear that action may be needed.

IV. General Recommendations (If Any):

Commentator Recommendation (Identify relevant sections when possible)	Commentator Rationale (Support for the recommendation)
Section 2.1: This streamlined definition of actuarial soundness seems fine, given most capitation rate development will reference 42 CFR 438.4 as the soundness definition.	N/A
Rate Amendments	We believe guidance on rate amendments would be valuable. In particular, guidance regarding when or if it is ever appropriate to update due to emerging experience.

V. Signature:

Commentator Signature	Date
Annette V James, MAAA, FSA, FCA Vice President, Health	August 27, 2026