ACAP | Association for Community Affiliated Plans

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FACT SHEET:

MEDICAID MANAGED CARE AND ACTUARIAL SOUNDNESS

"We have learned that manipulating capitation to meet a predetermined budget target, without reducing the MCO's medical cost exposure, will eventually destroy a Medicaid managed care program."

Anthony Rodgers, Arizona Medicaid Director
Testimony, Roundtable: Securing Medicaid's Future: Spotlight on Managed Care
Senate Special Committee on Aging

Introduction

Actuarial soundness is a quality ascribed to Medicaid payment rates for managed care organizations (MCOs) that are fair and adequate based on several defined criteria. It is an important tool for retaining the viability of Medicaid managed care as a legitimate alternative to Medicaid fee-for-service delivery systems. Actuarial soundness ensures that health plans serving state Medicaid programs are adequately reimbursed based on the cost of health care expenditures and the populations served.

Unfortunately, state budget pressures sometimes influence Medicaid agencies to develop capitation rates based on factors beyond the scope of the Medicaid program, such as the overall budget. However, to be actuarially sound, rates must be determined independent of budget considerations.

When states develop rates that are sound, plans are encouraged to participate in Medicaid, and maintaining adequate provider networks becomes easier. Payment of actuarially sound rates also protects plan enrollees by ensuring that plans have adequate funding to deliver health care services and by reducing the likelihood plans will become insolvent, leave Medicaid, and disrupt enrollees' continuity of care.

Statutory Authority

The Balanced Budget Act of 1997 expanded the ability of states to use managed care in their Medicaid programs. In so doing, Congress required that managed care organizations be reimbursed in a manner that is actuarially sound. Title XIX[i] provides the Centers for Medicare and Medicaid Services (CMS) with the authority for requiring actuarial soundness by stating that no payment shall be made to a managed care organization for Medicaid services to enrollees unless the contract between the state and MCO for those services allows for actuarially sound

prepaid payments. The statute further requires the Secretary of the Department of Health and Human Services (DHHS) to provide prior approval for these contracts.

Regulatory Authority

Rules promulgated by CMS in June 2002[ii] to explicate the statute provide additional guidance on the meaning of "actuarially sound capitation rates." According to the regulations, rates that are actuarially sound:

- 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.
- 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.

The preamble (the section of the regulation containing public comment and responses from CMS) to the 2002 rule also contains language indicating that states must develop rates independent of the state budget, basing rates instead on the expected cost of delivering managed care to each state's Medicaid populations. To this end, CMS responded to a comment regarding whether states are allowed to based actuarially sound rates on FFS budgets by saying that rather than use a budget-driven approach to determine rates, a Medicaid agency must determine whether the state budget is sufficient to begin or continue a Medicaid managed care program, either in advance of accepting bids for MCO contracts, or as a result of its inability to attract MCOs due to too-low rates.

Despite this, states may be tempted to use budgetary factors in developing capitation rates. Anthony Rodgers, Director of the Arizona Health Care Cost Containment System, provided an alternate state perspective when he testified before the Senate Special Committee on Aging that "It is a very short-sighted strategy to establish rates based on a predetermined budget figure. It may work for a year or so but will eventually create deterioration of managed care plan effectiveness and participation."

To uphold the regulations, CMS regional offices review Medicaid managed care capitation rates set by states using an "actuarial checklist" that requires states to describe their ratesetting methodology and the data used to arrive at rates, provide an actuarial certification of the capitation rates and payments under the contract, and give additional information. (The checklist does not include a check-off point assuring that budgetary factors were not used.) CMS approves rates for MCOs that adhere to this checklist.

External Interpretation

In January 2006, The Lewin Group developed a report for the ACAP and Medicaid Health Plans of America (MHPA) called *Rate Setting and Actuarial Soundness in Medicaid Managed Care*. This paper provides an overview of actuarial soundness and considers the challenge of simply

defining the term, which Lewin states traditionally (and loosely) means neither excessive nor inadequate. The paper also stresses that as just critical as the rates themselves is how they are developed. The study notes that regulations require that rates be based on utilization and cost data, that they reflect actual state plan benefits, and include inflationary trends, regional cost differences, managed care's cost containment effects and other factors. Lewin also provides a brief discussion on the Federal prohibition of using a budget-driven approach to develop rates and concludes that "Just as important as what the regulations say is what they do not say: they do not tie managed care payment rates to the "would-be" cost of providing the same benefits to the same population on a FFS basis. Nor do they tie the payment rates to whatever amount the state has budgeted for its Medicaid managed care program."

The American Academy of Actuaries (AAA) produced a Practice Note in August 2005 that broadly discusses actuarial soundness and draws a conclusion similar to that in the Lewin report regarding budgetary influences on the development of rates. (Although AAA Practice Notes serve as professional guidance to actuaries, including actuaries employed by or contracting with state Medicaid agencies, they do not *require* actuaries and states to follow particular practices.) The AAA writes that actuarially sound rates (or ranges of rates) depend on benefits and populations, and "are normally independent of budget issues unless benefits or populations change." The Practice Note continues to explain that "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."

The State Story

When states do not offer Medicaid health plans actuarially sounds rates, the consequences can be serious, both for the states *and* their Medicaid enrollees. Most recently, the State of Colorado lost one of two remaining MCOs serving its Medicaid program when Colorado Access left the program, partly as a result of unsound rates provided by the State. The State was forced to shift enrollees to other service delivery options, including the one remaining MCO serving the Medicaid program.

In 2007 health plans serving Michigan's Medicaid program are likely to face a 6 percent cut in rates, and analysts fear that this reduction will result in a reduction in provider rates, which in turn may inhibit enrollee access by reducing the provider network. The rate cut appears to be directly related to the $800 million budget shortfall in the State's budget.

Lewin's *Rate Setting and Actuarial Soundness in Medicaid Managed Care*, cited above, found that among the health plans studied, plans in one-half of the states indicated that payment rates are either explicitly budget-driven or are indirectly affected by budget constraints. In addition, thirty-nine percent of the plans (representing 5 of the responding states) say that the state generally is not responsive to their concerns about the rate-setting process, and that the final rates

often do not reflect all the factors that could have a material impact on the plans' cost of providing benefits.

Conclusion

Actuarial soundness is critical for ensuring the stability of Medicaid managed care programs because sound rates encourage ongoing participation of MCOs in Medicaid programs, which leads to a stronger likelihood of continuous, consistent care for Medicaid enrollees. The statute and regulation (including a clear indication in the regulation's preamble) governing actuarial soundness together provide guidance for states to develop fair rates that do not factor in budget considerations. Still, states may be tempted by budget pressures to develop rates that may not be entirely sound, based on the principles outlined above. The federal government through CMS has sole authority to ensure that states provide actuarially sound rates to MCOs serving Medicaid programs, and this authority should be consistently and firmly exercised.

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[i] Section 1903(m)(2)(A)(iii) of title XIX.
[ii] 42 CFR 438.6(c)