March 7, 2022

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–4192–P
P.O. Box 8013
Baltimore, MD 21244–8013

Re: Proposed Rule, Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs

To Whom It May Concern:

On behalf of the LTC Medicaid Subcommittee of the American Academy of Actuaries (Academy),[1] I am pleased to provide comments on the proposed rule: "Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs." Specifically, our comments will focus on the following provisions for which the Centers for Medicare & Medicaid Services (CMS) is seeking feedback:

- **Separate contracts under § 422.107(e):** The extent to which the proposal to allow states to require dual-eligible special needs plans (D-SNPs) with exclusively aligned enrollment to operate under separate contracts described at § 422.107(e) would better allow states to evaluate the performance of integrated plans.
- **Separate MLR Requirements:** The impact of separate Medicare and Medicaid medical loss ratio (MLR) requirements on meeting integration goals, administrative burden for plans, and others through separate MLR standards, and whether the current approach provides sufficient data for state decision-making and policy development.

[1] The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

- **Medicare Supplemental Benefits & Medicaid:** The impact of Medicare Advantage (MA) supplemental benefits and state-specific D–SNP requirements on Medicaid-related costs and capitation rate setting, particularly the extent to which consideration of the impact of Medicare-covered benefits on costs and utilization of Medicaid services advances integration goals and is consistent with actuarial standards of practice. Finally, CMS requested input on what information states, actuaries, and others would need to evaluate actuarial soundness under this approach.

Separate Contracts Under § 422.107(e)

It is important to recognize that many stakeholders already make regular efforts to collect and analyze both Medicare and Medicaid financial data to support the evaluation of integrated products and satisfy existing requirements. Examples include:

- Health plans offering integrated products may track both separate and combined MLRs for regular performance monitoring.
- State Medicaid agencies typically require detailed Medicaid financial information for rate setting and program monitoring. They may also request high-level Medicare financial information from organizations offering integrated products.
- CMS requires MA organizations with separate Medicaid contracts to report historical and projected Medicaid revenue and costs in MA bid pricing tool filings in addition to the detailed MA revenue and cost data that is required of all MA organizations.

Therefore, to the extent the changes proposed to § 422.107(e) further facilitates or standardizes states' analysis of all relevant financial information for integrated products where it is currently not possible, the proposed rule would help provide a more complete picture of the financial performance of integrated products.

Separate MLR Requirements

Regarding the impact of separate MLR requirements and the sufficiency of this data for policy development, with any MLR calculation, the quality and availability of the underlying data is crucial to ensuring the reliability of the analyses. One significant challenge in compiling separate MLR reports for highly integrated programs is the availability of complete, consistent, and accurate encounter data. For highly integrated programs, this typically includes encounter data for both Medicare and Medicaid liabilities and establishing a consistent framework for allocating Medicare- and Medicaid-covered costs. This issue is neither novel nor easily solved due to technical and legal hurdles, but overcoming it would represent a tremendous opportunity to enhance the reliability of Medicare and Medicaid and MLR reporting and rate setting, the ability to evaluate individual plans, and the measurement of overall progress against integration goals over time. It would also facilitate a substantial leap forward in supporting data-driven decision making and policy development for states and CMS alike for these programs.

Additionally, while many stakeholders already collect Medicare and Medicaid financial information at some level, no standardized method for calculating a combined MLR for integrated programs is currently in place. For instance, the separate MLR requirements for

Medicare and Medicaid use different credibility thresholds and operate under different frameworks and timelines. Therefore, CMS may wish to seek to ensure that combined MLRs calculated by various stakeholders are calculated in as consistent a manner as possible.

The proposal to calculate combined MLRs as a means of furthering integration goals suggests that a state could consider the expected profit/loss for a D-SNP's Medicare Advantage (MA) plan when negotiating with plans to cover services that would otherwise be covered by Medicaid as Medicare supplemental benefits; however, the proposed guidance does not extend the use of the combined MLR to capitation rate development. In the development of Medicaid capitation rates, actuarial soundness requirements under 42 CFR §438.4(a) specify that "actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract…"

In Financial Alignment Initiative (FAI) programs, there is one three-way contract between CMS, the state Medicaid agency, and the applicable Medicare-Medicaid plan (MMP). Therefore, the assessment of actuarial soundness for the Medicaid capitation rates under the FAI could consider both Medicare and Medicaid contributions, and efficiencies and savings that may be associated with Medicare.[2] The joint rate-setting process for the FAI reflects that "both payers proportionally share in the savings achieved through the demonstrations."[3]

Under the integrated D-SNP model, the D-SNP has an MA contract with CMS and a separate capitated contract with the state Medicaid agency. In this context, it is unambiguous that "the contract" to which 42 CFR §438.4(a) would apply is the D-SNP's capitated contract with the state Medicaid agency. Accordingly, the combined MLR may have important applications for supporting policy making decisions. Some of those policy decisions may create considerations that need to be accounted for in Medicaid rate development; however, only the Medicaid-specific MLR and projected MLR are considered by Medicaid actuaries when developing Medicaid capitation rates for an integrated D-SNP program. This is a contrast to the flexibility that allows Medicaid actuaries to consider the combined financial performance of Medicare and Medicaid contributions, and efficiencies and savings associated with both Medicaid and Medicare that exists in the FAI Medicaid capitation rate development process.

The proposed guidance also acknowledges that an integrated plan may show a low MLR for Medicare Advantage and a high MLR for Medicaid managed care due to the D-SNP delivering more Medicaid-covered services that result in decreases in Medicare-covered services (which could lead to an increase in the Medicaid capitation rates).[4] Further guidance and clarification on the use of combined MLR information in Medicaid capitation rate setting will be important to actuaries developing Medicaid capitation rates for these programs.

[2] "Approved Demonstrations—Signed MOUs"; CMS; Dec. 1, 2021. Accessed Feb. 19, 2022.
[3] *Joint Rate-Setting Process for the Financial Alignment Initiative's Capitated Model*; CMS; March 19, 2019. Accessed Feb. 19, 2022.
[4] "Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs"; *Federal Register*; Jan. 12, 2022. Accessed Feb. 19, 2022.

Medicare Supplemental Benefits & Medicaid

With respect to the direct and indirect impact of MA supplemental benefits on Medicaid costs and utilization, the following guidance defines what should be included in Medicaid capitation rates:

- 42 CFR §438.4(a) regarding actuarial soundness requirements for Medicaid capitation rates specifies that "actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract."
- Actuarial Standard of Practice (ASOP) No. 49, *Medicaid Managed Care Capitation Rate Development and Certification*, states: "Medicaid capitation rates are 'actuarially Sound' if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes."

Additionally, Medicaid is a secondary payer relative to Medicare. This means that to the extent MA Supplemental benefits impact cash flows that would otherwise be covered by Medicaid, they would need to be considered in developing Medicaid capitation rates in order to comply with actuarial soundness requirements. Accordingly, the framework proposed by CMS is consistent with relevant capitation rate guidance.

As it pertains to the question of what information is necessary to evaluate actuarial soundness under the proposed approach, Medicaid rate development exercises for programs with enrollment aligned between Medicaid and Medicare currently may utilize a wide variety of information about the corresponding Medicaid and Medicare programs that generally meet this need. Some of this information can be obtained from public sources, and others are routinely requested of health plans as part of the rate development process. Goals of this data collection include:

- Evaluating the consistency between base data and non-benefit costs used for Medicare bids and Medicaid rate development
- Considering combined program financial performance
- Understanding Medicare Advantage supplemental benefit design

Examples of health plan-specific Medicare program information often collected in Medicaid rate development include:

- Base period benefit expenditures, non-benefit expenditures and enrollment
- Historical financial experience for the Medicare portion of the aligned program and the combined program

- Descriptions of supplemental benefits offered under the Medicare program that may impact Medicaid-covered costs

At the same time, it is important to recognize that the mechanics of the proposed integrated D-SNP model present implementation challenges as compared to the FAI programs that should be considered in light of actuarial soundness. These challenges include:

- Timing—MA organizations do not finalize benefit designs until August after final Part D direct subsidy and regional low-income benchmarks are released by CMS. Reflecting MA benefit changes in calendar year Medicaid rates would be difficult given the requirement to submit Medicaid rates 90 days prior to the rating period, for states seeking contract approval prior to a specific effective date.
- Non-uniformity of benefits across plans—Each MA plan is likely to cover a different suite of supplemental benefits that may change significantly from year to year. At a minimum, this results in different MA supplemental benefit impacts by plan for programs with exclusively aligned enrollment. For unaligned products, each Medicaid plan could contain dual eligible beneficiaries that received Medicare benefits from dozens of different MA plans/benefit packages.
- Non-uniformity of benefits within MA plans—MA supplemental benefits that overlap with Medicaid benefits or otherwise affect Medicaid expenditures may be offered through recent MA benefit flexibilities that permit MA plans to offer benefits non-uniformly to not all members (e.g., uniformity flexibility, or special supplemental benefits for the chronically ill). The Medicaid actuary may not have the necessary information to estimate the target population and utilization rates for these non-uniform benefits.
- Medicare/Medicaid claim liability—as mentioned above, the lack of a consistent framework for allocating Medicare- and Medicaid-covered costs in encounter and cost report data may limit the state's visibility into the impact of program changes related to crossover claims.

In order to ensure consistency in how Medicaid actuaries approach these issues, additional guidance or consultation may be necessary, perhaps through the Medicaid Managed Care Rate Development Guide, regarding CMS' expectations for Medicaid actuaries in incorporating the impacts of MA supplemental benefits on Medicaid rate setting. In particular:

- Would CMS expect states and their actuaries to establish plan-specific Medicaid rates to account for differences in MA supplement benefits by plan?
- Would CMS be amenable to using historical MA benefit packages to establish Medicaid rates knowing that those MA benefit packages may change?
- Would a Medicaid certifying actuary be able to rely on another actuary's certification of the cost of supplemental benefits, or would the Medicaid actuary need to certify such adjustments independently?

- What quantitative support for such adjustments would be requested in CMS' review of the Medicaid rates?
- What efforts could be taken, and which stakeholders need to be involved, in developing a standardized Medicare/Medicaid cost allocation methodology for highly integrated programs financial reporting?

****

The Subcommittee appreciates the opportunity to provide comments on the proposed rule, "Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs." We welcome the opportunity to speak with you to provide more detail and answer any questions you might have regarding these comments. If you have any questions or would like to discuss further, please contact Matthew Williams, the Academy's senior health policy analyst, at williams@actuary.org.

Sincerely,

F. Ronald Ogborne III, MAAA, FSA, CERA
Chairperson, Long-Term Care Medicaid Subcommittee
American Academy of Actuaries