June 30, 2023

Centers for Medicare and Medicaid Services (CMS)
Department of Health & Human Services (HHS)
CMS–Attention: 2439–P
P.O. Box 8016
Baltimore, MD 21244–8016

Re: Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality (CMS-2439-P)

To Whom It May Concern,

On behalf of the Medicaid Committee of the American Academy of Actuaries (the Committee),[1] I appreciate the opportunity to provide comments on the notice of proposed rulemaking (NPRM), *Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality* (Managed Care NPRM) released on May 3, 2023.[2]

Summary of the Proposed Rule

As outlined by CMS:

This rule is focused on addressing additional critical elements of access: (1) potential access (for example, provider availability and network adequacy); (2) beneficiary utilization (the use of health care and health services); and (3) beneficiaries' perceptions and experiences with the care they did or did not receive.

To obtain these objectives, the proposed rule addresses:

- Timely access to care, monitoring, and enforcing efforts
- Reducing burdens for some state directed payments (SDPs)
- Reducing burdens for certain quality reporting requirements
- Adding new standards for in lieu of services (ILOS)
- Specifying medical loss ratio (MLR) requirements
- Establishing a quality rating system for Medicaid and CHIP managed care plans

[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.
[2] "Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality"; Federal Register; May 3, 2023.

The committee's comments focus on the following sections of the Managed Care NPRM that are more financially focused: 1) SDP changes; 2) ILOS standards; 3) MLR requirements; and 4) rate transparency and payment analysis requirements.

References

In developing our comments, the Committee relied upon individual and collective expertise and combined multiple decades of experience in Medicaid and CHIP managed care actuarial rate-setting and other actuarial issues and the following three additional source documents:

- Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule[3]
- 2023–2024 Medicaid Managed Care Rate Development Guide[4]
- Actuarial Standard of Practice (ASOP) No. 49, *Medicaid Managed Care Capitation Rate Development and Certification*[5]

Comments on Proposed Rule

- The committee appreciates CMS efforts to increase the Medicaid programs' transparency. With the Managed Care NPRM, CMS has made several positive policy advances in this regard. We ask that CMS consult with states and their health plan partners to consider both the administrative burden and lead time necessary for state programs and actuaries to comply with the finalized rule. The rate-setting process typically begins six to nine months before the contract effective date. Material changes to reporting would lengthen that timeframe and increase administrative funds necessary to support additional actuarial work, especially in the initial year of the rule.

- The expected cost and burden of the Managed Care NPRM are of significant concern to state staff and their Medicaid Managed Care Organizations (MCOs) partners. As written, the proposed rule seems to suggest that additional staff resources, time, and money will be needed for state compliance. This additional funding relative to historical state expenditures and state budgeting timelines should be considered by CMS. In addition, MCOs will be subject to increased reporting and analysis requirements.

- The committee's comments reflect our recognition that health plan-employed actuaries and state-employed actuaries understandably have different perspectives. Each group or individual brings valuable experience, expertise, and perspective to any discussion. While finalizing the rule, CMS should carefully consider each perspective, whether contained within this letter or elsewhere.

Detailed Comments and Questions

State Directed Payments (42 CFR 438.6[6], 438.7[7], 430.3[8])

[3] "Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care"; *Federal Register*; Nov. 13, 2020.
[4] *2023-2024 Medicaid Managed Care Rate Development Guide; Department of Health & Human Services*, Centers for Medicare and Medicaid Services; May 2023.
[5] Actuarial Standard of Practice No. 49, *Medicaid Managed Care Capitation Rate Development and Certification*; Actuarial Standards Board; March 2015.
[6] "§ 438.6 Special contract provisions related to payment"; Code of Federal Regulations; National Archives; June 13, 2023.
[7] "§ 438.7 Rate certification submission"; Code of Federal Regulations; National Archives; June 13, 2023.
[8] "§ 430.3 Appeals under Medicaid"; Code of Federal Regulations; National Archives; June 13, 2023.

The committee thanks CMS for considering the certifying actuary's role in developing and including SDPs in Medicaid managed care capitation rates. We understand that CMS' preference that SDPs are part of the at-risk contract between states and health plans and to establish guidelines around maximum benchmarks. However, some proposed changes may negatively impact states' ability to design efficient programs, support access through provider reimbursement, or leverage provider reimbursement strategies to achieve their quality goals.

We include specific comments and questions on items included in the SDP section of the Managed Care NPRM below.

- § 438.6(c)(a)—This section proposes a definition of separate payment terms as an arrangement with a predetermined and finite funding pool paid outside of base capitation rates. It is unclear why separate payment terms would be limited to finite funding pools. States may need flexibility to implement uniform percentage or dollar reimbursement increases that are paid on a per-unit basis and not subject to a predefined limit. This would have the benefit of more closely tying provider payments to service utilization and would provide states flexibility to utilize separate payment terms to address steerage concerns or other policy limitations related to inclusion of these payments within base capitation.

- § 438.6(c)(1)(iii)(A) and (B)—The 2020 final rule exempted SDPs with minimum fee schedules based on State Plan rate methodologies from the preprint review. In the Managed Care NPRM, CMS proposes to also exempt SDPs using minimum fee schedules based on 100% of Medicare fee schedules from submitting a preprint because, as noted by CMS:

  > *Consistent with how we have considered State plan rates to be reasonable, appropriate, and attainable under §§ 438.4 and 438.5, Medicare approved rates too meet this same threshold.*

  If CMS is determining that two distinct points of reimbursement are "reasonable, appropriate, and attainable," we suggest that any fee between a State Plan rate and 100% of Medicare should also be exempt from the preprint process as it falls between these two approved points of reference as an additional way to ease state burden. (e.g., 90% of Medicare if that is greater than the State Plan rate).

- § 438.6(c)(1)(iii)(B)—Medicare serves a different age and risk-profile demographic than Medicaid. Because Medicare fees are an imperfect analogy for Medicaid, some deviation around the Medicare fee should be allowed for preprint exemption—for example, 100% of Medicare ±10% points.

- § 438.6(c)(2)(ii)(H)—In the preamble, CMS notes that states could either obtain hold harmless attestations or require MCOs to obtain each provider's attestation. We suggest that the process for gathering attestations requires only one attestation be collected per provider. If each MCO were required to collect attestations, the process would be duplicative and administratively burdensome.

- § 438.6(c)(2)(iii)—Medicaid is the leading payor for nursing facilities, unlike inpatient, outpatient, and physician payments, as outlined in the metrics included in the Managed Care NPRM by CMS. In addition, CMS stated that only 2% of the SDPs that are currently bringing provider payment levels close to an average commercial rate (ACR) were for nursing facilities. Due to the limited availability of non-Medicaid data, it may be challenging to develop a reliable ACR benchmark for these services. Therefore, the committee suggests removing nursing facilities from the ACR limit.

To the extent that CMS is seeking an alternative to the ACR benchmark for nursing facility services, we encourage the consideration of a cost-based benchmark. This approach would create a more reliable benchmark than ACR, which is still state-specific and market-based, to evaluate nursing facility SDPs against. Additionally, we do not believe it would be appropriate to use the cost-based nursing facility benchmarks to establish a limit on nursing facility SDPs (e.g., nursing facility reimbursement rates, inclusive of SDP amounts, cannot exceed 100% of the cost-based nursing facility benchmark) in the way that the ACR benchmark is used for non-nursing facility SDPs.

- § 438.6(c)(2)(iii)(C)—Allowing for three years between ACR demonstrations is a welcomed proposal to reduce state burden. However, the ACR would be static between demonstrations under the proposal, whereas medical trends are not. The committee suggests that a provision for trending the ACR be included in the preprint to estimate the ACR level across the three-year approval period. This change would allow for calculating trend effects on the ACR between demonstrations.

- § 438.6(c)(2)(vii)—CMS notes its concern about SDPs where states require plans to make interim payments based on historical utilization and then reconcile to current utilization at a later period. It is unclear if this concern is based on reliance on historical utilization from before the rating period, the existence of interim payments, or a reconciliation with the potential for recoupment of payments from providers and plans.

  Using historical data is a common practice in the development of Medicaid capitation rates. For example, prospective rate setting is performed using historical data as the base period data on the premise that historical data is reasonably informative of the future on average.

  If utilization from only within the rating period is required for SDP payments, one of the following approaches would be required:

  - The state must wait for sufficient claim payment runout to avoid needing to make material adjustments for reporting uncertainty. Otherwise, the adjustments themselves would use historical data. The time needed for data to be completed would vary depending on the type of service. However, it is a common actuarial practice to use data with at least six months of payment runout after the end of the time period (e.g., CY 2022 data with runout through June 2023). This approach would result in payment delays to providers.

  - If the state wishes to make payments during the rating period using rating period data, then an incurred but not yet reported (IBNR) adjustment may be needed to estimate final payments. Actuaries calculate IBNR estimates from completion patterns using historical utilization. This historical data would include utilization from outside of the rating period. In addition, depending on the amount of runout incorporated into the calculation, IBNR uncertainty may have a significant impact on accuracy of the payments.

  Many states currently select the first option above and wait for sufficient complete data to be available for the final payments while using interim payments to ease providers' cash flow.

  Alternatively, if CMS is concerned about potential recoupments from providers as part of a reconciliation process, CMS could propose a reduction in interim payment calculations to reduce

the likelihood of recoupments rather than prohibiting interim payments entirely. For example, if a state is making quarterly payments, it makes four of them at 80% of the expected quarterly amount. The reconciliation is then expected to result in a payment to providers, on average, rather than a recoupment. If this approach were taken, sufficient time should be allotted to allow providers to plan for cash flow changes.

With these considerations, we ask that CMS continue to allow states the flexibility to make interim payments based on historical utilization data (or projected utilization) and reconcile them to rating period utilization. Allowing interim payment approaches does not change the ultimate financial obligation of state and federal governments, so the benefits of a prohibition need to be clarified.

- § 438.6(c)(5)—CMS proposes that states document required fee schedules in MCO contracts. This requirement would include certain information about the procedure codes and diagnosis codes to which the fee schedule applies. The committee suggests broadening the language because fee schedules can be based on other codes such as Diagnosis Related Groups (DRGs), Ambulatory Payment Classifications (APCs), and Revenue codes, to name a few.

Specific commentary regarding separate payment terms was requested by CMS

CMS is considering, and invites comment on, requiring all SDPs to be included only through risk-based adjustments to capitation rates and eliminate the State's ability to use separate payment terms altogether in the final rule based on comments received.

While requiring all cost components other than certain taxes and fees to be included in the capitation rates on a risk basis is consistent with the prospective nature of capitation rate setting, CMS should consider the following when finalizing these rules:

- Some states use separate payment terms to mitigate steerage concerns. Prohibiting these separate payment terms could result in access issues or steerage away from certain providers, including some who may be essential safety net providers.

- Based on our experience, separate payment terms are often a special type of uniform dollar or percentage increase payment where the overall additional funding will be unknown to providers until their actual volume of services is known. Additionally, in a fixed pool case, reimbursement to a provider depends on the volume of services relative to other providers.

- Transitioning SDPs from separate payment terms to risk-based adjustment in the capitation rates would introduce funding risks to both the state and the MCOs. As such, this transition would require an increase of the overall risk margin built into the capitation rates. The transition would remove uncertainty around the uniform dollar or percentage increase to providers on a per-service basis because that uniform amount will have to be predetermined in the rate-setting process. However, when using a fixed pool, there may be added uncertainty for states and plans. For states and MCOs, the financial obligations would be based on enrollment and utilization of services without the ability to manage a fixed pool. Additionally, such a transition could shift market dynamics, impacting referral patterns, access, and utilization in ways that may be difficult to predict. It could also create perverse incentives, whereby MCOs exclude certain providers with large SDP arrangements from their networks, creating inequities across MCOs and misalignment between capitation rates and service spending in states where common base rates are used for all MCOs.

- Capitation rates are at-risk because there is uncertainty related to service use by beneficiaries which drives most plan expenditures. However, fixed pools of money, especially legislated ones, are incompatible with this uncertainty. Suppose the actuary calculates a per-member per-month amount by dividing the fixed pool by forecasted enrollment. Then, if forecasted enrollment is different from actual enrollment—and it will be—the total amount paid out via MCOs' capitation rates would differ from the fixed amount allocated in the state budget or the per-member per-month amount would need to be amended to reflect actual enrollment.

- Any significant changes from current policy should be coupled with sufficient lead time for states, plans, and providers to develop and implement transition plans that identify and mitigate risks to Medicaid enrollees and the providers and plans serving them.

Limit on SDP expenditures

CMS also requested comments regarding establishing a limit on total SDP expenditures. The committee does not believe that a limit on these expenditures in aggregate is appropriate or necessary, given the following reasons:

- The number and size of SDP arrangements may vary by state based on need, quality goals, or strategic initiatives. These objectives are typically documented by states in the detailed preprints, which are subject to review and CMS approval. The amount approved by CMS for each SDP establishes a cap that CMS has determined to be reasonable and appropriate for that specific arrangement. Therefore, we suggest that CMS continue to provide states with the flexibility to design custom programs that include SDPs, based on the merits of each SDP, without an overall cap.

- CMS is proposing the implementation of SDP limits that they believe are appropriate for certain categories of service (e.g., average commercial rates). We believe this category limit should supersede the need to establish an overall expenditure cap on SDPs to support equity and access across provider types and programs.

- Imposing a cap based on the percentage of capitation within a managed care program could lead to inequities across providers, delivery systems and states. For example, a state that hits the cap based on a separate payment term for one provider type would be limited in providing similar arrangements to other provider types. Additionally, two states with similar separate payment terms could have significantly different percent-of-capitation results. In this example, suppose one state had carved out the pharmacy benefit while the other had not but both had the same SDP numerator. One state may be within the cap while the other is not due only to program design unrelated to the SDP.

- The comparison to a proposed limit on ILOS may not be appropriate, as SDPs serve a different purpose than ILOS.

If CMS is considering a limit on total SDP expenditures, we believe that it is appropriate to wait until CMS has had sufficient time to review the SDP evaluation reports to be submitted by states, as outlined in the NPRM.

In Lieu of Services and Settings (ILOSs) (§§ 438.2, 438.3, 438.7, 438.16, 438.66, 457.1201, 457.1207)

The committee understands the direction to increase transparency to ensure that ILOS are medically appropriate and cost-effective substitutions; however, the aggregate impact of the various new reporting and documentation standards for ILOS would collectively be administratively burdensome to states. For states with ILOS that are largely consistent year over year, these additional requirements may offer limited value to CMS. We include specific comments and questions on items included in the ILOS section of the Managed Care NPRM below.

§ 438.16(c)(1)—Introducing a 5% ILOS cap would remove flexibility on a state-by-state basis to design programs that deliver quality care in a cost-effective manner. The following are examples of potential consequences of an ILOS cap:

- States at risk of exceeding the 5% ILOS cost percentage may forgo experimenting with a new ILOS if they think it will put them at risk of going over 5% on the ILOS cost percentage.

- A state offering an ILOS in only a portion of the state through a regional plan may be limited in expanding a proven ILOS statewide due to the implementation of a cap, which could cause equity issues within the state.

- A state with a comprehensive managed care program offered to some beneficiaries and a more limited managed care program offered to other beneficiaries may be able to offer a certain ILOS to beneficiaries in the comprehensive managed care program that they are unable to offer to beneficiaries in the limited program due to lower per capita capitation amounts.

- A state with pharmacy benefits carved out of managed care may be limited in the ILOS they could offer relative to a similarly situated state with pharmacy in managed care.

CMS compares the 5% ILOS cap to the 5% incentive limit on MCO incentive arrangements at §438.6(b). However, we do not believe that this is an equivalent comparison because MCO incentive payments are made in addition to the certified capitation rates, while ILOS are considered part of the benefit expense component of the base capitation rates and are by definition cost-effective substitutions for otherwise covered services. Additionally, MCO incentive arrangements are not subject to the robust reporting requirements for ILOS that are outlined in the Managed Care NPRM. Similar to the discussion on SDP expenditure limits that was noted above, we believe that the rigorous review and evaluation process for ILOS approval, along with the associated estimated costs, should be sufficient for demonstrating the reasonableness and appropriateness of these arrangements instead of an overall cap on these types of services.

We suggest CMS consider the following:

- Do not implement a ILOS cap % but do include additional reporting or transparency provisions to understand any ILOS offered with a significant cost (ILOS with expenditures below a certain threshold should be exempt from robust reporting requirements to mitigate administrative burden on states).

- Allow grandfathering of ILOS in managed care contracts before a defined date to allow for the

continuation of those ILOS offerings, reducing potential disruption to enrollees.

- Exempt home and community-based services (HCBS), behavioral health, and other services where ILOS benefits are needed to ensure access to quality care and address policy priorities such as deinstitutionalization and addressing substance use disorders and mental health conditions.

§ 438.16(c)(2) and 438.16(c)(3)—The final ILOS cost percentage appears to be nearly identical to the projected ILOS cost percentage other than "actual total capitation payments" versus "projected total capitation payments." It seems the final ILOS percentage is duplicative of other parts of the Managed Care NPRM because § 438.16(c)(4) is proposed to capture actual ILOS amounts instead of only the ILOS proportion attributable to the rates. CMS should clarify the rationale for requiring a final ILOS cost percentage when the projected ILOS cost percentage is provided and the final percentage is not expected to vary materially from projected.

§ 438.16(d)(2)—The 1.5% ILOS threshold for robust documentation is described to be a risk-based approach to managing state administration burden (i.e., eliminating burden when the ILOS demonstrates low risk to the capitation rates). Given the requirement that ILOS be cost-effective, it is unclear what risk needs to be managed. If the concern is relative to uncertainty related to new health related service needs (HRSNs), the requirements should be limited to those specific ILOS, rather than all ILOS. Additionally, rather than apply robust documentation requirements to all ILOS when a state exceeds an aggregate threshold, CMS should consider setting a minimum threshold for each ILOS so the reporting requirements only apply to a subset of services that are of material size. This partitioning would reduce the risk that the cost of documenting the ILOS exceeds the actual ILOS expenditures.

§ 438.16(e)(1)(i)—Calculating ILOS percentages by program would burden states that have non-integrated programs. In addition, smaller programs would naturally have higher fluctuation in ILOS percent year-to-year. CMS should allow states to pool programs for the ILOS percentages or require integrated programs to calculate ILOS percentages by major service types like physical health, behavioral health, or long-term services and supports within the single program (with a higher threshold to offset the narrower denominator). These suggestions would bring increased parity across different program designs, noting that CMS would need to consider appropriate limits for each service type to support the intended policy goals.

§ 438.16(e)(1)(iii)(C)—Using historical data to study an ILOS interaction with State Plan services may be difficult for an ILOS that has already been in place for years. The data will not have a "before" or "after" the implementation of the ILOS to study. The cost, access, or equity impacts of the introduced ILOS may be unobservable because enough time has elapsed for the program to be in a service equilibrium. Instead, we recommend CMS require this type of report only if a noticeable shift has happened in the ILOS cost percentage or for the introduction of new ILOS. For example, if the percentage changes ±X% points between rating periods, that may be enough to look for correlated impacts in State Plan services or changes in equity outcomes.

§ 438.16(e)(1)(iv)—For states with ILOS cost percentages consistently above 1.5%, this provision would seem to require annual submission of rolling five-year retrospective evaluations. For example, in CY 2025, a state has a prospective and retrospective ILOS cost percentage >1.5%. In 2030 the state would submit a retrospective evaluation based on the past five years of data, per § 438.16(e)(1)(ii). Suppose in CY 2026, the state still has an ILOS cost percentage >1.5%. Would the state be submitting

yet another five-year retrospective evaluation in 2031? The report would be like the 2030 report but with one new year of recent data replacing the oldest of the past five years of data. Is it CMS' intent that states continuously submit a rolling five-year retrospective evaluation? As an alternative, CMS could consider requiring states to update ILOS evaluations every X years, like how §438.6(c)(2)(iii)(C) allows for three-year breaks between ACR demonstrations.

Medical Loss Ratio (MLR) Standards (§§ 438.8, 438.3, and 457.1203)

The committee includes specific comments and questions on items included in the MLR section of the Managed Care NPRM below.

§ 438.74(a)(3)—Defining an SDP amount for separate payment terms is straightforward because the amount is easily tracked as it is paid separately from capitation. However, other SDPs embedded in capitation are more complex to capture. For example, a state may set a minimum fee schedule SDP. The actuary would include a program change amount to get the base data up to the SDP minimum fee schedule. In this example, clarity would be needed with respect to whether the MLR reporting from MCOs to states and states to CMS should include the incremental change amount to get to the minimum fee schedule or the amount inclusive of the base payments. Clarity would also be needed regarding whether treatment of amounts above the minimum fee schedule would be reported. The same concept applies for maximum fee schedules. It may be challenging for MCOs to identify their share of the SDP to report. To minimize the burden and potential inconsistencies in reporting, CMS should consider only requiring separate MLR reporting for separate payment terms.

Rate Transparency and Payment Analysis (§§ 438.207(b)(3) and 438.207(d))

The following comments and questions related to the financial aspects of the proposed rate transparency and payment analysis requirements are primarily requesting clarification:

- § 438.207(b)(3)—MCOs would provide a payment analysis using paid claims data (utilization) from the immediately prior rating period. Differences in the mix of services between MCOs would affect average payment levels. For example, an MCO serving more acute members would likely have a higher average payment level driven by a greater prevalence of more intense codes. To remedy this situation, we suggest that states provide statewide utilization or a market basket of utilization that all MCOs could use to weight their fee schedule. This would normalize the mix of services between MCOs and provide more comparable results.

- § 438.207(b)(3)(i)—Managed care plans are required to report the following payments to states: evaluation & management codes for primary care, OB/GYN, mental health, and SUD services. At § 438.2, "behavioral health" services are being redefined as "mental health and substance use disorder (SUD)". Does that mean that mental health and SUD services would be grouped as one service type for the reporting requirements at § 438.207(b)(3)(i), or would they be considered separate service types?

  In addition, the Medicare fee schedule does not include every Medicaid service. Will CMS provide methodology to manage procedure codes that are used by the state but are not included in the Medicare fee schedule? Also, would CMS consider proposing simplified methodology for the Medicare fee schedule that health plans could use for this comparison?

- § 438.207(b)(3)(i)—The payment analysis for homemaker services, home health aide services, and personal care services include a comparison to the state FFS fee schedule. How should this analysis be completed if there is no state FFS fee schedule available. For example, if managed care is the only program covering these services?

- § 438.207(b)(3)(i)—CMS proposes to require separate percentages for adult and pediatric services, such as preventive, primary care, specialty services, and long term services and supports (LTSS). How would this be defined? Some codes are used for both adult's and children's services. If CMS would like to compare payments for adults and children separately, the committee suggests using beneficiary age on claims to define services for children and adults rather than designating each service as being specific to either children or adults.

- § 438.207(b)(3)—Are the analyses described at § 438.207(b)(3) inclusive of any SDPs?

- § 438.207(b)(3)(i)—States have FFS schedules of various ages since updated or services with a rate. Normalizing unit costs to FFS may create misleading or incomparable statistics. For example, consider two states that have an average managed care unit cost of $50 for a certain service. If one state recently updated its FFS rate to $45, but the second state's FFS rate has remained at $25 due to a lack of fee schedule updates, the cost percentages would be markedly different (111% vs. 200%) despite having the same underlying rates. We suggest that CMS consider requiring states to report an average unit cost instead of a FFS comparison. This would also reduce administrative burden for states that lack a FFS rate or have not made updates to FFS rates.

- § 438.207(d)(2)(ii)—Outlines a requirement for States to weight the data from "plans' reported payment analysis percentages using member months associated with the applicable rating period to produce a Statewide payment percentage for each service type." Weighting by member months implies the same service utilization levels across plans. Further, plans may be only in some geographies, which can inform access and utilization. Therefore, weighting the plan's reported payment analysis percentages by claims volume to produce a statewide payment percentage for each service type may be more accurate than using member months.

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The committee appreciates the opportunity to provide comments on the Managed Care NPRM and welcomes the opportunity to speak with you in more detail and answer any questions you have regarding these comments. If you have any questions or would like to discuss further, please contact Matthew Williams, the American Academy of Actuaries' senior health policy analyst, at williams@actuary.org.

Sincerely,

Julia Lerche, MAAA, FSA
Chairperson, Medicaid Committee
American Academy of Actuaries