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OCTOBER 2023

Leveraging Medicaid Rate-Setting Strategies to Promote Financial Integration in D-SNPs

Opportunities and Barriers for Federal and State Policymakers to Consider

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This report was made possible through the generous support of Arnold Ventures.

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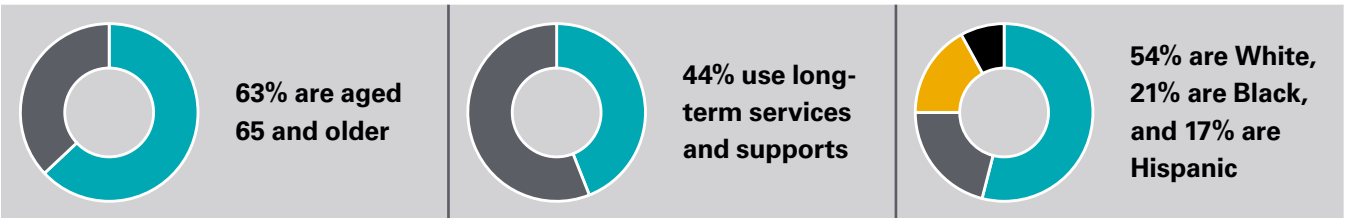
Introduction

In the United States, individuals are eligible for Medicare because they are aged 65 or older or because of their long-term disability status, and they are typically eligible for Medicaid because they have low income and few assets. Over 12 million Americans are eligible for both Medicare and Medicaid (i.e., dual-eligible individuals), and many are aged 65 or older, have complex health needs, and are racially diverse.[1]



Dual-eligible individuals also account for a disproportionate share of spending in both programs: 19% of Medicare and 14% of Medicaid enrollees are dual-eligible, but they contribute to about one-third of spending in each program.[2] Medicare and Medicaid are governed by different rules across a range of areas, such as eligibility and enrollment, provider networks, and covered benefits, and have separate financing mechanisms. This can result in fragmented coverage, uncoordinated care, and misaligned financial incentives for dual-eligible individuals, despite the level of complexity and high cost of this population.

To address challenges created by the disconnected systems, federal and state policymakers have implemented a number of approaches to better coordinate and integrate care and financing across Medicare and Medicaid, including through Medicare Advantage (MA) dual-eligible special needs plans (D-SNPs). Specifically, all D-SNPs must have contracts with state Medicaid agencies (i.e., State Medicaid Agency Contracts, or SMACs) that meet specific federal requirements, including Medicare-Medicaid integration to improve coordination across the two programs. States can include additional requirements in the SMAC beyond the federal requirements, such as additional care management or data-sharing mandates.

Today, there is growing interest from Congress in advancing integrated care models.[3] The Centers for Medicare & Medicaid Services (CMS), in the CY 2023 Medicare Advantage and Part D Final Rule, also signaled its preference for states to use fully integrated dual-eligible special needs plans (FIDE-SNPs) or highly integrated dual-eligible special needs plans (HIDE-SNPs) as the primary vehicles for integrating care for dual-eligible individuals.[4] (See Figure for a description of the types of MA D-SNPs.)

Figure: Types of Dual-Eligible Special Needs Plans (D-SNPs)

D-SNP Type	Access	Brief Description
Fully Integrated D-SNP (FIDE-SNP)	12 States	• Same legal entity operating the D-SNP is capitated by the state to cover Medicaid long-term services and supports (LTSS) • Covers other Medicaid benefits (including behavioral health) as long as the state does not decide to carve those benefits out of the capitated contract • Has coordinated are delivery and coordinates or integrates certain administrative functions • **New**: Starting in 2025, FIDE-SNPs must operate with exclusively aligned enrollment and cover Medicaid home health; medical supplies, equipment and appliances; behavioral health services through a capitated contract with the state Medicaid agency
Highly Integrated D-SNP (HIDE-SNP)	16 States and the District of Columbia	• D-SNP's parent company is capitated by the state to cover Medicaid behavioral health and/or LTSS benefits through the D-SNP or an affiliated Medicaid managed care plan • **New**: Starting in 2025, each HIDE-SNP's capitated contract with the state for coverage of Medicaid benefits must apply to the entire service area for the D-SNP
Coordination-Only D-SNP	35 States	• Coordinates Medicaid benefits for members (e.g., by connecting members with Medicaid benefits) • Must notify the state or the state's designee of hospital and skilled nursing facility admissions for a group of designated high-risk enrollees • May be capitated to cover some Medicaid benefits

Source: Adapted from Kolber, M., et al. What Health Plans Should Know About Federal Changes for Dual Eligibles. December 2022. Available at https://www.manatt.com/Manatt/media/Documents/Articles/What-Health-Plans-Should-Know-About-Federal-Changes-for-Dual%c2%a0Eligibles-12-15-22_v4.pdf; MACPAC, Chapter 5: Raising the Bar: Requiring State Integrated Care Strategies, June 2022.

Despite the growth of the D-SNP market, D-SNP access and integration levels vary across the country. There is opportunity for states to pursue more integrated care models (particularly FIDE-SNPs or HIDE-SNPs) that promote financial integration and lead to improved access, care delivery and health outcomes for dual-eligible individuals.[5]

In the January 2023 report supported by Arnold Ventures, Manatt Health highlighted the following two complementary strategies that state policymakers may deploy to improve financial integration of Medicare and Medicaid:[6]

- **Benefit Design**: States may influence the design of the FIDE-SNP benefit to drive efficient resource allocation across Medicare and Medicaid and seamless, holistic, and equitable care for dual-eligible individuals. For example, states can leverage the D-SNP model of care (MOC) as a vehicle for aligning and integrating benefits and care coordination across Medicare and Medicaid services within FIDE-SNPs.
- **Medicaid Rate Setting**: Working with their actuaries, states may assess and incorporate more broadly in their Medicaid rate-setting processes expected savings to their Medicaid programs arising from their aligned benefit design and integrated care. Specifically, the preamble to the CY 2023 Medicare Advantage and Part D Final Rule (Final Rule), endorsing the approach outlined in the proposed rule, confirmed that Medicaid capitation rates can be actuarially sound if they consider "[t]he impact of MA supplemental

benefits and any State-specific requirements in the State Medicaid agency contract, D-SNP MOC, or Medicare-Medicaid plan (MMP) contract on the costs and utilization of the Medicaid benefits covered by the Medicaid managed care capitation rates." This reaffirms the ability of state Medicaid agencies to consider MA spending and requirements in Medicaid capitation rates, including potential savings that may accrue from integration.

Currently, the CMS Medicaid Managed Care Rate Development Guide (Guide) contemplates dual-eligible members enrolled in D-SNPs in the Medicaid rate-setting process. However, CMS has not provided further guidance on how states and their actuaries can operationalize the approach endorsed in the Final Rule preamble. Having clear and specific guidance from CMS on how to reflect potential efficiencies accruing from integrated care in Medicaid rate setting, as well as specific examples of opportunities that state Medicaid agencies and their actuaries may pursue, could encourage more states to expand access to integrated care programs that can better coordinate whole-person care and connect people with necessary long-term services and supports (LTSS) and social support services.[7] This may lead to higher beneficiary satisfaction, a better care experience, and ultimately, improved health outcomes and health equity for dual-eligible individuals, who are racially diverse and have more complex health needs.[8]

To address the gaps in care for dual-eligible individuals, this report, also supported by Arnold Ventures, outlines:

1. **Federal opportunities, including potential CMS rulemaking and guidance, that can support states in implementing financial integration approaches**: States may be hesitant to adopt approaches to financial integration without additional guidance from CMS. Thus, this report includes potential avenues and proposed programmatic guidance for CMS to consider, including sample language for sub-regulatory guidance (e.g., Medicaid rate-setting instructions), to provide guidelines and clarifications for how states can adopt and implement the approach endorsed in the Final Rule.
2. **State opportunities to achieve financial integration**: This report also explores the Medicaid rate-setting strategy in more detail than the previous report, with a focus on policy, actuarial, and regulatory considerations for states and their actuaries. The report provides concrete examples of ways in which state policies related to integrated care models involving D-SNPs may be reflected in Medicaid rate setting. For each example, this report includes an overview and a discussion of key policy, actuarial, and practical implementation considerations.

In developing this report, the authors identified and interviewed key stakeholders familiar with D-SNPs, Medicaid rate setting, and federal and state Medicaid policy for dual-eligible individuals. Interviewees included state Medicaid policymakers, Medicaid actuaries, D-SNP health plan leaders and actuaries, thought leaders, and consumer representatives. Interviews were conducted with groups of stakeholders to understand their views on the federal and state opportunities and barriers to further financial integration in ways that impact Medicaid rate setting. This report synthesizes the discussions with interviewees, additional research, the Manatt authors' Medicaid program and policy expertise, and the Milliman authors' actuarial experience working with state Medicaid agencies and health plans on Medicaid rate setting and MA bid development.

Federal Policymaker Opportunities—Advancing CMS Rulemaking and Guidance to Support Financial Integration

For this report, and under existing Medicare and Medicaid financing systems, "financial integration" means holistic consideration of Medicare and Medicaid program dynamics and interactions in the financing of programs for dual-eligible individuals. This report focuses on facilitating financial integration through D-SNP models by enabling states to assess and incorporate in Medicaid rates potential efficiencies resulting from integrated care.

Under the current statutory framework, Medicaid managed care capitation rate development and the MA bid process are separate and distinct. However, there is opportunity within both rate-setting structures to promote financial integration for dual-eligible individuals. For example, Medicaid agencies and their actuaries have some flexibility within the development of "actuarially sound" capitation rates that provide reasonable, appropriate, and attainable costs required within regulatory and actuarial standards.[9,10] The MA D-SNP bid process, which is established by federal statute and regulation, is more prescriptive but provides flexibility for MA plans to incorporate state requirements, as documented in the state's D-SNP SMAC, either implicitly or explicitly in MA plan bids, with certain restrictions.

During interviews, stakeholders shared that concrete instructions from CMS would be welcome on the types of expenditures that can be considered as permissible savings for dual-eligible individuals from integrated care (see the State Policymaker Opportunities section for potential examples), as well as ways to estimate the components of savings and meet the "actuarial soundness" requirement for Medicaid capitation rates. CMS could use various vehicles to provide states, actuaries and other stakeholders with guidance, considerations, and clarifications, which will support successful state adoption and implementation of Medicaid rate-setting strategies and promote financial integration.

Key vehicles to achieve the aims listed above are outlined in the table below. At CMS' discretion, the agency could also bring states together through learning collaboratives to provide direct technical assistance on the guidance and facilitate state learnings.

CMS Vehicle	Purpose	Primary Intended Audience	Regulatory or Sub-regulatory	Examples of Potential Areas for Inclusion
Regulation	Require or direct specific action	State Medicaid agencies, managed care plans, providers, and community-based and advocacy organizations	Subject to federal rule making	• Authority for states to adopt certain rate-setting approaches to promote financial integration • Requirement for state action on approaches to integrated care or approaches to Medicaid rate setting for dual-eligible individuals

CMS Vehicle	Purpose	Primary Intended Audience	Regulatory or Sub-regulatory	Examples of Potential Areas for Inclusion
CMS' Medicaid Managed Care Rate Development Guide	Provide guidance and considerations for ensuring the appropriateness and completeness of actuarially certified capitation rates	State Medicaid agencies and actuaries	Sub-regulatory	• Clear guidance to states and their actuaries on what CMS believes should be considered in Medicaid rate setting for dual-eligible individuals
State Medicaid Director Letters	Clarify and communicate further guidance set forth in regulations for the Medicaid program	States Medicaid agencies, managed care plans, providers, and community-based and advocacy organizations	Sub-regulatory	• Additional guidance and examples to states and their policy teams on how to make changes to their programs for dual-eligible individuals, in conjunction with Medicaid rate-setting processes to advance financial integration
CMS Informational Bulletins	Share information, address issues, and highlight best practices	State Medicaid agencies, managed care plans, providers, and community-based and advocacy organizations	Sub-regulatory	• Best practices or specific state examples for state policy teams, related to Medicaid rate setting for dual-eligible individuals
CMS Frequently Asked Questions	Clarify understanding of existing policy	State Medicaid agencies, managed care plans, providers, and community-based and advocacy organizations	Sub-regulatory	• Clarifications on how states and their actuaries may collect or use certain data, or on other common implementation questions from states related to changes to their programs to promote financial integration

Federal Regulations

The most onerous option available to CMS is federal regulation, but it would allow CMS to mandate certain actions and to publish information in the Federal Register to reach a broad audience. Changes to federal regulation may be required if CMS wants to mandate that states adopt some or all of the approaches to integrated care for dual-eligible individuals or to Medicaid rate setting for dual-eligible individuals. However, most of the financial integration options discussed in the prior section are unlikely to need new federal regulation.

CMS' Medicaid Managed Care Rate Development Guide

The CMS Guide may be an appropriate place for the agency to issue guidance to states and their actuaries on what CMS believes should be considered in Medicaid rate setting for dual-eligible individuals, including Medicare-related information. For example, CMS may use the Guide to ask states how they have considered Medicare data or changes in the Medicare program in Medicaid rate setting.

Among sub-regulatory options, the authors of this report believe that revisions to the Guide could have the most immediate and broad impact on Medicaid rate setting. However, it may not include all of the details needed for implementation or be an effective vehicle if CMS intends to disseminate information to a broader audience, given that the Guide is published on the Medicaid website and specifically targets states and their actuaries. Sample Guide language is included below.

State Medicaid Director Letters (SMDLs)

SMDLs may be an appropriate avenue for CMS to issue clear guidance, instructions, and examples to states and their policy teams. SMDLs may be a more appropriate avenue for disseminating information to states that are looking to change their programs for dual-eligible individuals in conjunction with updating their Medicaid rate-setting processes to advance financial integration efforts. Such changes could include SMAC or MOC changes that may impact rate development. For example, CMS could use SMDLs to provide guidance for states that wish to make changes in the SMAC or MOC to require MA plans to cover certain services under Medicare. A change to the SMAC or MOC that impacts covered benefits should then be considered by the actuary in developing Medicaid capitation rates. The SMDL would be published on Medicaid's website and would reach the broader audience needed to implement the financial integration options.

CMS Information Bulletins (CIBs)

CIBs may be useful in publishing information highlighting certain information, such as best practices, processes, or specific state examples, related to Medicaid rate setting for dual-eligible individuals. CIBs are more likely to be targeted to state policy teams, but they still may be useful for reaching a broader audience. For example, a CIB describing how Washington has incorporated Health Homes in its D-SNP MOC coordination requirements may be useful in helping other states consider this or similar options in their programs for dual-eligible individuals. This CIB would be published on Medicaid's website and would reach the general public, as well as the audience that will be implementing the financial integration options.

CMS Frequently Asked Questions (FAQs)

CMS FAQs may be helpful in providing limited guidance or clarification on how states and their actuaries may collect or use certain data. However, they are unlikely to reach a broad audience. CMS FAQs still may be a useful document for answering common questions states may have in implementing changes to their programs for dual-eligible individuals. For example, CMS FAQs may be useful in helping states understand the Medicare data available to them for advancing their dual-eligible programs.

Sample Medicaid Managed Care Rate Development Guide Language

During the interviews, stakeholders, including actuaries and states, requested additional CMS guidance and considerations for reflecting efficiencies deriving from integrated care for dual-eligible individuals in Medicaid rate setting. While additional sub-regulatory or regulatory guidance may be needed to endorse a specific approach, CMS may be able to provide additional guidance and structure to actuaries through the Guide.

If CMS would like to provide more guidance to Medicaid actuaries via the Guide without endorsing a specific approach, the agency could consider adding a new section to the Guide specifically addressing rates that include dual-eligible individuals. Similar to the current layout of the Guide with its unique Managed Long-Term Services and Supports (MLTSS) and New Adult Group Capitation Rates sections, a new section specific to dual-eligible individuals would allow CMS and actuaries to itemize the considerations that are unique to Medicaid capitation rate setting for this population and for integrated programs.

An illustrative outline for a new section, modeled on the current New Adult Group Capitation Rates section, is below. Note that the list of considerations included in this outline is not intended to be exhaustive, but instead reflects key issues identified by stakeholders during the interviews conducted as part of the research for this report. The proposed language in the sample section of the Guide is not intended to be prescriptive but is meant to promote transparency in the rate-setting process. For example, Section I below does not require the actuary that will set rates for Medicaid services for members covered under D-SNPs to review MA bid pricing tools (BPTs), the MOC, the SMAC, or other information from the state or managed care organizations to aid in understanding the impact of this information. Rather, the actuary would only be required to disclose which, if any, of the sources they considered and how they considered these sources in rate development. CMS may consider expanding the guidance in the Guide to include a broader list of considerations such as rate cell structure, risk adjustment, and other key elements of Medicaid rate setting for dual-eligible individuals.

I. Data

   A. In addition to the expectations for all Medicaid managed care rate certifications, the rate certification must describe the data used to develop rates for dual eligibles enrolled in the Medicare Fee-for-Service (FFS) program, MA plans, and D-SNPs, particularly where different or additional data was used.

   B. The certification must document whether the following data sources specific to dual eligibles were used and describe how they were used:

      1. Medicare FFS claims or Medicare Advantage (MA) encounter data
      2. Medicare enrollment data
      3. Medicare Advantage Bid Pricing Tools (BPTs)
      4. Special Needs Plan (SNP) Model of Care (MOC)
      5. State Medicaid Agency Contract (SMAC), and
      6. Other data specific to Medicare enrollees.

II. Projected Benefit Costs

A. In addition to the guidance for all Medicaid managed care rate certifications described in Section I of the Guide, states should include in the rate certification submission and supporting documentation a description of the following issues related to the projected benefit costs for the dual-eligible group:

1. How changes to the Medicare FFS and Medicare Advantage programs between the base data period and the rating period were considered in projected benefit cost development.
2. How supplemental benefits offered by MA plans were considered in projected benefit cost development.
3. How differences in the timing of MA and Medicaid contract periods were considered in projected benefit cost development.
4. How provider reimbursement rates, including state lesser-of policies, were considered in projected benefit cost development.
5. The expected effect that Medicare and Medicaid integration will have on utilization and the unit cost of services.

B. The rate certification and supporting documentation should document how changes in state policies for dual eligibles from the base period to the rating period were considered in rate development, including impacts to unit cost, utilization, acuity, and other projected benefit cost drivers.

III. Projected Non-Benefit Costs

A. The rate certification and supporting documentation must include key assumptions related to the projected non-benefit costs, such as the following:

1. The data sources and methodology used to develop the projected non-benefit costs
2. The extent to which dual-eligible integration status, the MOC, and the SMAC were considered in developing the following items, and the allocation between Medicare and Medicaid:
    a. Administrative costs
    b. Care coordination and care management
    c. Provision for operating or profit margin
    d. Taxes, fees, and assessments
    e. Other material non-benefit costs
3. How the operating or profit margin was developed, and the extent to which Medicare performance and the impact of integrated care were considered in the development of margin
4. Other material non-benefit costs

IV. Final Capitation Rates

A. In addition to the expectations for all Medicaid managed care rate certifications described in Section I of the Guide, CMS requests states that covered dual eligibles in Medicaid managed care plans in previous rating periods to provide a description of any other material changes to the capitation rates or the rate development process not otherwise addressed in the other sections of this guidance.

B. Describe how final capitation rates consider past and projected Medicaid medical loss ratios (MLRs) by plan.

C. If Medicare costs and revenue were considered in rate development, please also describe how final capitation rates consider past and projected combined Medicaid and Medicare MLRs by plan.

V. Risk Mitigation Strategies

In addition to the expectations for all Medicaid managed care rate certifications described in Section I of the Guide, CMS requests that states document the extent to which impacts of Medicare and integrated care are considered in the risk mitigation process.

State Policymaker Opportunities—Advancing Financial Integration Through Medicaid Rate Setting for D-SNPs

Manatt Health and Milliman outline a variety of opportunities below, informed by stakeholder interviews, that state Medicaid agencies and their actuaries may pursue to account for impacts from financial integration in Medicaid rate setting. Where possible, we provide examples of states already deploying these strategies. As discussed above, CMS guidance, instructions, and/or technical assistance could facilitate states pursuing some of these opportunities.

Medicaid Program Savings

Options 1 through 4 listed below are Medicaid program savings opportunities that some states already have adopted. Further guidance and permission from CMS may encourage more states to implement these options.

1. Administrative savings resulting from integration

- Increased integration between the Medicaid and Medicare benefits may allow for the D-SNP and Medicaid plan to reduce duplicative administrative functions (e.g., member materials, grievance and appeals processes, etc.), resulting in administrative cost savings to the Medicaid plan. States may reflect prospectively in their Medicaid rates any expected Medicaid administrative savings that likely would result from eliminating duplicative administrative functions or implementing other efficiencies.

Policy and Actuarial Considerations

A key consideration for states and actuaries when calculating these administrative cost savings is that MA organizations may use different approaches for how they allocate an expense across lines of business and across MA plans. There may also be differences in how they classify some expenses in their MA bid—as an administrative cost versus a medical cost—due to MA bid requirements. The Medicaid savings adjustment should consider these differences. Further guidance from CMS regarding the allocation of administrative

costs across Medicare and Medicaid for dual-eligible individuals could be helpful for states, health plans, and actuaries. Additional administrative costs may be associated with integrated care models depending on the program structure and state policy. For example, data-sharing requirements with the state could increase information technology and other administrative costs.

Administrative cost savings due to efficiencies may be most practical and impactful for D-SNPs (including FIDE-SNPs) with largely or exclusively aligned enrollment.

- States may reduce Medicaid liability for administrative costs by making a policy decision to require D-SNPs in the SMAC to cover certain administrative activities that are typically covered by Medicaid (such as functional needs assessments) but also are covered by Medicare.

Policy and Actuarial Considerations

For this option, D-SNPs or one of their contracted providers will be completing the administrative activities instead of the Medicaid plan. States may need to ensure coordination between D-SNPs (other than FIDE-SNPs) and the Medicaid plan. For all D-SNPs, states may need to ensure that dual-eligible individuals have access to all needed Medicaid services. In order to reflect the savings in Medicaid rate development, Medicaid actuaries will need to understand the cost savings attributable to Medicaid and any offsetting expenses as a result of increased coordination with the D-SNP.

This approach could apply to any D-SNP but may be most practical and impactful for D-SNPs (including FIDE-SNPs) with largely or exclusively aligned enrollment.

2. Program savings resulting from D-SNP coverage of Medicare services that overlap with Medicaid

- States may reduce Medicaid capitation rates prospectively to D-SNPs to reflect payments for Medicare-covered services that overlap with Medicaid or for MA plans covering Medicaid's Medicare cost-sharing liability for dual-eligible individuals enrolled in D-SNPs. Overlapping medical costs may result from Medicare policy, state policy, or voluntary plan design decisions by MA organizations offering D-SNPs.

Policy and Actuarial Considerations

To consider these savings options, actuaries should understand Medicare policy and D-SNP benefit offerings. For example, beginning January 1, 2023, MA plans were required to count Medicaid cost-sharing payments made by the state or Medicaid managed care plan, including where payments were not made due to lesser-of policies, to the

Case Study: California

- Due to the overlap between the Medi-Cal Enhanced Care Management (ECM) benefit and the D-SNP MOC requirement, California excludes dual-eligible individuals in exclusively aligned enrollment (EAE) D-SNPs from enrolling in ECM, and it will align state-specific D-SNP MOC requirements with ECM requirements over time.
- These MOC requirements are included in the SMAC and Medicaid rate setting—California makes a downward ECM rate adjustment for dual eligibles to account for the overlap in services rendered.

individual's maximum out-of-pocket (MOOP).[11] For MA plans that were not already accumulating these costs to the individual's MOOP, there could be savings to the Medicaid agency that could be reflected in the Medicaid rates.

A change in federal Medicare policy may impact all dual-eligible individuals—including those not enrolled in a D-SNP—while a change in a specific MA organization's benefits will only impact dual-eligible individuals enrolled in that MA plan.

Actuaries should also consider that changes in Medicare-covered benefits could increase costs in some cases. For example, annual increases in the Part B deductible directly increase Medicaid costs.

- States may actively align care management services included in the D-SNP MOC with those under the Medicaid care management benefit for dual-eligible individuals. By including the care management services within the D-SNP MOC, the care management costs can then be considered Medicare benefit costs within the MA bid development process, and state Medicaid actuaries can reflect the lower care management service costs attributable to Medicaid in Medicaid rates. Key stakeholders expressed interest in further guidance from CMS, including guardrails, regarding the use of the SMAC and MOC to require care management activities.

Policy and Actuarial Considerations

To consider these savings options, actuaries should understand Medicare policy and D-SNP benefit offerings from the SMAC or MA bid materials (including BPT, Plan Benefit Package, and MOC). Notably, for states that have mature integrated programs, the base data used to develop Medicaid rates may already reflect these savings.

3. Program savings resulting from D-SNP coverage of supplemental benefits

- States may make the policy decision to incent or mandate D-SNP coverage of certain supplemental benefits in the SMAC and then incorporate the potential impacts of the coverage requirements in Medicaid rates. MA organizations may also voluntarily cover services through Medicare supplemental benefits that would otherwise be covered by Medicaid.

Policy and Actuarial Considerations

A coverage mandate of supplemental benefits may have several downstream impacts:

- Actuaries may need to account for the coverage requirements in the MA bid development process.
- There may be implications with respect to D-SNPs' ability to compete within the broader MA market and provide services that meet the unique needs of their dual-eligible individuals. These implications on D-SNPs may vary based on the type, quality ratings, and size of the D-SNP (e.g., smaller plans may have less flexibility to offer additional supplemental benefits to attract individuals).[12]
- The impact of the policy decision on D-SNPs may differ depending on their member profile, contractual arrangements, or financial situation based on their quality ratings, which can change annually. This may require Medicaid actuaries to consider setting plan-specific rates to reflect the differences in supplemental benefit costs and coverage.

- D-SNPs may react to state requirements by making different benefit design or contracting decisions, which may affect dual-eligible individuals' access to providers and services.
- A change in state policy may impact all dual-eligible individuals enrolled in a D-SNP, while a voluntary change in a specific MA organization's supplemental benefits will only affect the dual-eligible individuals enrolled in that MA plan.
- To address these potential impacts, states may want to begin by gaining a better understanding of D-SNP supplemental benefit offerings in relation to the Medicaid benefit package to identify gaps. States can do this by adding specific reporting requirements in the SMAC or as a competitive bid element in Medicaid procurements, and by working directly with D-SNPs to define supplemental benefits in a way that meets dual-eligible individuals' needs and preserves market competitiveness.

4. Program savings resulting from state investments in Medicaid Home and Community-Based Services (HCBS) and behavioral health services

- One goal of state Medicaid agencies' investments in HCBS (e.g., home care, respite, or adult day health) and behavioral health services (e.g., outpatient psychiatric services, crisis services, or integrated care services) for dual-eligible individuals is a reduction in utilization of acute or post-acute medical services such as hospital, emergency department (ED), or skilled nursing facility (SNF)visits or stays. Reduced utilization may lead to reduced Medicaid spending on cost sharing for Medicare services and/or reduced Medicaid nursing home costs, which could be captured prospectively in the Medicaid rate-setting process.
- Many states with MLTSS programs utilize blended rates (i.e., the same capitation rates for beneficiaries in nursing homes as those receiving LTSS in the community) to incentivize managed care organizations to invest in providing HCBS to dual-eligible individuals in the community rather than institutional care in nursing facilities. This rate-setting approach does not require an integrated program but would nonetheless be possible in integrated programs that include LTSS.

Policy and Actuarial Considerations

Depending on state programmatic and policy priorities and funding allocation, states may issue policy guidance and make investments in HCBS and behavioral health services to enable dual-eligible individuals to stay in their homes longer and potentially reduce inpatient hospital, ED, and SNF/nursing home costs. However, the cost of investing in HCBS and behavioral health may not immediately produce Medicaid savings and may instead result in short-term costs to the Medicaid program. The costs or savings from this option will need to be regularly reviewed, may depend on the level of integration (i.e., coordination-only D-SNPs versus FIDE-SNPs), may change over the long term, and may be challenging to quantify. Actuaries would also require clinical or empirical evidence to support the inclusion of prospective savings assumptions.

Holistic Medicare and Medicaid Funding

Some interviewed stakeholders suggested that CMS could clarify to what extent states and actuaries may directly or indirectly recognize Medicare funding as part of the Medicaid rate-setting process. Explicit language in CMS guidance authorizing these approaches or clarifying the extent to which they can be pursued could facilitate states' pursuing the following two options.

1. Reflecting Medicare financing in Medicaid rate-setting processes

- Some interviewed stakeholders suggested that CMS could allow states and actuaries to consider developing Medicaid rates using a "total cost of care" approach by projecting dual-eligible individuals' total premium for both Medicare and Medicaid services and setting the Medicaid rate as the total cost (including benefit costs, non-benefit costs, and margin) less the Medicare funding.
- Some interviewed stakeholders suggested that CMS could allow states and actuaries to also consider historical and expected MA profits when determining an appropriate profit margin in the Medicaid capitation rate.

Policy and Actuarial Considerations

Current federal regulations define "actuarially sound" capitation rates as those that are appropriate for the costs required under the terms of the contract, which could be interpreted strictly as the Medicaid contract. Under this interpretation, whether a total-cost-of-care approach is allowable is unclear. Explicit CMS guidance and clarifications would help states and their actuaries understand the extent to which Medicare costs and revenue can be considered in setting actuarially sound Medicaid capitation rates, including any limitations. CMS may also clarify its position on the state's ability to include Medicare experience as part of the Medicaid MLR requirement. Lastly, the MA bid instructions may need to be revised for MA actuaries to accurately project MA revenue and profit under this approach.

MA revenue, costs, and profitability are influenced by many factors including Medicare policy, plan operations, market conditions, and MA plan decisions. States and their actuaries may require knowledge of both Medicare and Medicaid rate setting, experience, and capacity to pursue this option. Results are likely to vary across plans in ways that may be difficult for states and their actuaries to predict.

MA bid instructions have strict gain and loss requirements, and MA MLR calculation and minimum requirements may differ from state Medicaid requirements. In the CY 2023 Medicare Advantage and Part D Final Rule, CMS stated that the agency does not believe it has the statutory authority to include Medicaid experience as part of the Medicare MLR requirement.[13] However, CMS has not addressed whether states can include Medicare experience in the Medicaid MLR calculations.

Lastly, there may be downstream impact on both Medicare and Medicaid program design and provider reimbursement, which could impact access to services. Therefore, states may need to implement additional monitoring and enforcement actions.

2. Reflecting Medicare financing in a holistic MLR

- Some interviewed stakeholders suggested that CMS could allow states to attribute savings generated from integration (e.g., from improved care coordination or increased use of HCBS) to Medicaid at a share that is higher than Medicaid's share of baseline expense, assuming integration is driving disproportionate savings in Medicare expense. For example, states may hypothetically apply a combined MLR to both Medicaid and Medicare savings and allow Medicaid to split the D-SNP's share of Medicare savings.

  Policy and Actuarial Considerations

  As noted above, CMS has not addressed whether states can include Medicare experience in the Medicaid MLR calculations, and there may be downstream impacts on Medicaid program design, provider reimbursement and market competitiveness. The actuarial considerations for this option likewise mirror those outlined above.

All the savings options outlined above generally apply to all types of D-SNPs, including HIDE-SNPs and FIDE-SNPs. However, the level of complexity in implementing these options and the amount of potential savings accrued may vary depending on the type of D-SNP. FIDE-SNPs may realize the greatest overall (Medicare and Medicaid) savings over time, largely because this is the most integrated D-SNP model—it covers Medicaid LTSS and behavioral health services in addition to Medicare services—and all FIDE-SNPs will have exclusively aligned enrollment in 2025. It may also be easier for FIDE-SNPs to implement the savings opportunities given that they will be coordinating comprehensive services and can more easily monitor implementation, share data, and quantify savings over time.

Practical Considerations Critical to the Success of Implementation

To enable the successful implementation of the savings options described above, CMS, states, and actuaries should consider practical factors that are not directly related to Medicare or Medicaid rate setting, including but not limited to those discussed below.

Benefit Designs

As described in the first January 2023 report, the Medicaid rate-setting strategy complements and works in conjunction with the benefit design strategy to promote financial integration. States may work with their D-SNP partners to strategically design an aligned benefit package to ensure seamless care delivery experiences and enhanced access to services for dual-eligible individuals; minimize confusion about their care providers, care managers, and covered benefits; and drive efficient resource allocation across Medicare and Medicaid. CMS could provide guidance including best practices and examples to help states develop aligned benefit packages.

As an example, as noted in the "State Policymaker Opportunities—Advancing Financial Integration Through Medicaid Rate Setting for D-SNPs" section above, to account for Medicare covered services savings, states may leverage the D-SNP MOC or SMAC to align and integrate care coordination or care management across Medicare and Medicaid services. States may also actively require D-SNPs to cover certain supplemental benefits that complement Medicaid-covered services or are intended to avert the need for intensive Medicaid-covered LTSS or nursing home benefits.

Required Medicare Information

Timely access to accurate Medicare data, including Medicare-related claims, utilization, and MA bid information, is crucial for states and their actuaries to develop actuarially sound Medicaid rates that reflect relevant Medicare experience. Currently, while some states collect Medicare data as part of the reporting from plans or receive Medicare FFS data from the CMS state Data Resource Center, Medicare data available to states and their Medicaid actuaries can be limited, outdated, and/or incomplete.

To address this challenge on the ground, CMS could provide additional technical assistance to states on ways to improve Medicare data sharing. New York, for example, requires its D-SNPs to share, within 10 business days of CMS' approval of their annual MA bid filing, both the original and final (approved) bid filing submissions.[14] Similarly, Florida and its actuaries historically had access to Medicare bid information and were able to use Medicare bid and Medicaid data to project the total premium needed for both Medicare and Medicaid.

Relatedly, access to the SMAC, D-SNP MOC, and MA bid materials could be valuable for Medicaid actuaries to understand Medicare benefit offerings and their potential rate impacts.

Timeline Alignment

As noted earlier, state Medicaid rate years commonly are aligned with the state fiscal year, while the MA bid and contract timelines are set according to the calendar year. CMS may consider encouraging states to shift Medicaid rate development for D-SNPs to align with the MA bid timelines or to adjust their rate development assumptions to account for each MA plan's bid and benefit package within the calendar year.

To address this challenge, Florida, for example, aligned its Medicaid rate-setting timeline for dual-eligible individuals with the MA bid process to be on a calendar-year basis, while its other Medicaid rate-setting processes are different (starting in October).[15] States may also adjust the capitation rate for D-SNPs mid-fiscal year to align with the Medicare calendar year, which could require the state to seek additional federal approval for the rate changes as actuarially sound.

Downstream Implications and Mitigation Strategies

As described in the "State Policymaker Opportunities—Advancing Financial Integration Through Medicaid Rate Setting for D-SNPs" section, building Medicare-related savings into Medicaid rates may have downstream implications on D-SNP market competitiveness, benefit design, and provider payment reimbursement. These impacts could disrupt beneficiary access to services and D-SNP enrollment, which could disproportionately impact the most vulnerable dual-eligible individuals.

CMS could encourage stronger state enforcement and monitoring to ensure access to needed services for dual-eligible individuals. Broad stakeholder engagement is also necessary to demonstrate the value of integrated care and improved financial integration to states, D-SNPs, providers, and most important, the dual-eligible individuals the programs serve.

Actuarial Soundness

Medicaid capitation rates are required to be actuarially sound. Per 42 CFR § 438.4, "actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care plan for the time period and the population covered under the terms of the contract."

CMS could provide more clarity to states and actuaries on the appropriate incorporation of the impacts of integration and integrated financing on actuarially sound Medicaid rate setting. As an example, CMS could issue guidance as to whether the actuarial standard-of-practice requirements that capitation rates are appropriate for the populations to be covered and the services to be furnished under the contract include both Medicare and Medicaid revenue and services, or only Medicaid revenue and services.

State Capacity and Rate-Setting Knowledge

States' knowledge of Medicare and their staff capacity to pursue and implement the financial integration strategies outlined above may be limited. Therefore, technical support and ease of implementation are immensely important. States may also need to contemplate whether and how financial integration fits into their priority goals and policy concerns related to integrated care/dual-eligible individuals. CMS could emphasize and provide additional context for the importance of financial integration for improving state integrated care/dual-eligible individual programs.

Relatedly, CMS has Medicare and Medicaid actuaries who are developing and/or reviewing rates through separate processes. There may be value in "cross-pollination" of Medicare and Medicaid rate-setting knowledge within the agency and with states, including providing state trainings or technical assistance.

Conclusion

By strengthening the integration requirements across all D-SNP models in the CY 2023 Medicare Advantage and Part D Final Rule, CMS has signaled its preference for states to use D-SNPs as the primary vehicle for integrating care for dual-eligible individuals.[16] This report identifies concrete opportunities for CMS and states to improve Medicare and Medicaid financial integration through D-SNPs by considering the interactions in the financing of integrated care programs and consequently reflect these efficiencies in Medicaid rate-setting for D-SNPs. As new FIDE-SNP requirements go into effect in 2025 and MMPs are scheduled to sunset prior to January 2026, FIDE-SNPs with exclusively aligned enrollment will be the most integrated managed care program option for dual-eligible individuals as measured by enrollment alignment and coverage of substantially all Medicare and Medicaid services.[17] D-SNPs have potential to improve financial integration as

illustrated through the approaches and examples outlined in this report. Achieving financial savings could encourage more states to expand access to integrated care programs for dual-eligible individuals through D-SNPs, particularly through the FIDE-SNP model.

This report describes specific Medicaid rate-setting approaches and examples for CMS, state policymakers, and their actuaries to consider. It also highlights potential vehicles CMS can use to provide guidelines and clarification for state adoption of these approaches, which stakeholders described as critical for implementation. For successful operationalization of these options, stakeholders also highlighted the need for timely access to Medicare data, alignment in the MA bid and Medicaid rate-setting timelines, and expanded state staffing capacity and knowledge of Medicare, among other enablers. By considering the approaches and examples presented in this report, policymakers, actuaries, and other stakeholders can better understand the potential financial impacts and savings opportunities associated with integrated care models for dual-eligible individuals.

Limitations

This report was commissioned by Arnold Ventures to support promotion of dual-eligibles integration through D-SNPs. This information is intended to provide state Medicaid agencies, CMS, state and federal policymakers, actuaries, and other interested parties with information related to approaches that reflect financial integration in Medicaid rate-setting for dual-eligible individuals.

The opinions stated in this article are those of the authors and do not represent the viewpoint of Milliman.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Nick Johnson and Annie Hallum are members of the American Academy of Actuaries and meet the qualification standards for sharing the information in this article. To the best of their knowledge and belief, this information is complete and accurate.

This report is intended to provide information related to Medicaid rate setting for integrated programs for dual-eligible beneficiaries. The list of considerations outlined in this article is not exhaustive. This information may not be appropriate, and should not be used, for other purposes.

Milliman does not intend to benefit from and assumes no duty of liability to parties who receive this information. Any recipient of this information should engage qualified professionals for advice appropriate to its own specific needs.

[1] Medicare Payment Advisory Commission (MedPAC) and the Medicaid and CHIP Payment and Access Commission (MACPAC), *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid*, February 2023, https://www.macpac.gov/wp-content/uploads/2023/02/Feb23_MedPAC_MACPAC_DualsDataBook-WEB-508.pdf.

[2] Ibid.

[3] In November 2022, a bipartisan group of senators released a request for information (RFI) seeking comments on ways to improve care integration for dual-eligible individuals and "to build a lasting, effective legislative solution." In May 2023, based on the RFI comments, Senator Cassidy released draft legislation for targeted stakeholder feedback that would provide states with support to establish integrated care programs for dual-eligible individuals.

[4] CY 2023 Medicare Advantage and Part D Final Rule, May 2022, https://www.federalregister.gov/documents/2022/05/09/2022-09375/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and.

[5] MACPAC, *Evaluations of Integrated Care Models for Dually Eligible Beneficiaries: Key Findings and Research Gaps*, August 2020, https://www.macpac.gov/wp-content/uploads/2019/07/Evaluations-of-Integrated-Care-Models-for-Dually-Eligible-Beneficiaries-Key-Findings-and-Research-Gaps.pdf.

[6] S. Anthony, A. Fiori, A. Traube, *Opportunities to Promote Financial Integration for Dual-Eligible Individuals*, Manatt Health, January 2023, https://www.manatt.com/Manatt/media/Documents/Articles/AV-Duals-Financial-Integration-Manatt-Final-Report_c.pdf.

[7] RTI International, *Addressing Social Determinants of Health in Demonstrations Under the Financial Alignment Initiative*, June 2020, https://innovation.cms.gov/data-and-reports/2021/fai-sdoh-issue-brief.

[8] Center for Health Care Strategies/MLTSS Institute, *The Value of Pursuing Medicare-Medicaid Integration for Medicaid Agencies*, November 2019, https://www.chcs.org/media/ADvancing-States-Value-of-Integration-Report-1119_4.pdf.

[9] 42 CFR § 438.4-5, -7; Actuarial Standard of Practice (ASOP) No. 49.

[10] The Commonwealth Fund, *Medicare Advantage: A Policy Primer*, May 3, 2022, https://www.commonwealthfund.org/publications/explainer/2022/may/medicare-advantage-policy-primer#12.

[11] Prior to January 1, 2023, MA plans were allowed to choose whether to count Medicaid cost-sharing payments as patient pay costs accumulating to the Medicare MOOP amount. Effective January 1, 2023, CY 2023 Medicare Advantage and Part D Final Rule (CMS-4192-F) clarified that all Medicaid payments paid on behalf of the individual should be included. It also extended payments made on behalf of the individual to include instances when Medicaid did not make a payment due to policies where states do not pay if Medicare already paid more than the Medicaid rate (lesser-of policies). CY 2023 Medicare Advantage and Part D Final Rule, May 2022, https://www.federalregister.gov/documents/2022/05/09/2022-09375/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and.

[12] In addition to covering traditional Medicare Part A and B benefits, MA plans, including FIDE-SNPs, are allowed to use their plan rebates (e.g., the refund resulting from MA plan bids that are below the MA rate-setting benchmark) to provide additional or supplemental benefits and/or reduced cost-sharing for beneficiaries, including dual-eligible individuals. In recent years, CMS has expanded the scope of supplemental benefits that MA plans can offer using a portion of their MA rebates to include LTSS and social determinants of health-related services, as well as allowed MA plans to cover Special Supplemental Benefits for the Chronically Ill that are not primarily health-related for certain chronically ill beneficiaries. The amount of an MA plan's rebate also depends on the star rating, which measures the plan's quality performance.

[13] CY 2023 Medicare Advantage and Part D Final Rule (CMS-4192-F), May 9, 2022, https://www.federalregister.gov/documents/2022/05/09/2022-09375/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and.

[14] New York State Department of Health, *State Medicaid Agency Contract*, 2024, https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/2024/docs/cy2024_sma_contract.pdf.

[15] Florida Agency for Health Care Administration, Medicaid Actuarial Services, 2023, https://ahca.myflorida.com/medicaid/medicaid-finance-and-analytics/medicaid-data-analytics/medicaid-actuarial-services.

[16] In the CY 2023 Medicare Advantage and Part D Final Rule, CMS is also sunsetting the federal Financial Alignment Initiative's MMPs by no later than December 2025, with a potential transition of MMP enrollees to integrated MA D-SNPs. MMPs feature a three-way contract that allows for passive enrollment, integrated member materials, and the distribution of shared savings to states.

[17] Programs of All-Inclusive Care for the Elderly (PACE) also are fully integrated programs that provide comprehensive Medicare and Medicaid services to dual-eligible individuals, typically in adult day health care settings.

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