PUBLIC MEETING

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COMMISSIONERS PRESENT:

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CHAIR THOMPSON: Good morning. Thanks, everybody, for giving us a few extra moments to finish up our Executive Session. We're very pleased to have a focus this morning on prescription drug pricing, and we have some great panelists to help us think about some innovative ways of addressing some of the issues that we've been discussing.

Chris, you are going to introduce our panelists, and then, as has been our practice, we will have an opportunity for the Commissioners to ask questions of the panelists, then we'll have a break, and then we will reconvene for a Commissioner discussion reflecting on what we've heard and what that might suggest in terms of our going-forward propositions.

Chris.

### PANEL: STATE INNOVATIONS IN DRUG PRICING

MR. PARK: Great. Thank you.

Today's panel continues the Commission's discussion on Medicaid's coverage of prescription drugs and the challenges states face in managing drug spending. Last
December, you heard about the management tools that states currently use to control utilization of spending and how the current tools are somewhat limited when it comes to high-cost specialty drugs. Today's panel will further this discussion by talking about the innovative coverage and payment policies that they are pursuing that go beyond the current management tools used by states.

With us today are Dr. Rebekah Gee and Dr. Paul Jeffrey. Dr. Gee is the Secretary of Louisiana's Department of Health. Her oversight responsibilities include public health and other direct service programs for citizens in need, such as behavioral health, developmental disabilities, aging and adult services, emergency preparedness, and the Medicaid program. Dr. Gee is an obstetrician and gynecologist and has served in numerous state and national policy roles.

Dr. Gee will talk about Louisiana's efforts to create a subscription model to pay for curative hepatitis C drugs for its Medicaid and prison populations. In August, the state released a Request for Information on the mechanics of how the subscription model would be implemented.
Dr. Jeffrey is the Director of Pharmacy in the Office of Clinical Affairs for Massachusetts Medicaid and is responsible for the state's pharmacy benefit for approximately 1 million of MassHealth's members. He is also an Associate Professor of Family Medicine and Community Health at the University of Massachusetts Medical School and currently serves on the Board of Directors of the Academy of Managed Care Pharmacy.

Dr. Jeffrey will discuss the goals of the pharmacy proposals in the state's recent Section 1115 waiver request, which was ultimately denied by CMS, and the state's payment policies for cell and gene therapy.

Many state and federal policymakers have expressed interest in new coverage in payment policies to address the high cost of certain drugs. While it is too early to know what Medicaid-specific policies may arise, given the upcoming changes in Congress, the innovations that both states are pursuing may serve as models for policymakers to consider in the future.

And with that I will turn it over to Dr. Gee.

* DR. GEE: Good morning. Can you hear me?

CHAIR THOMPSON: Yes, indeed.
DR. GEE: Good morning. Thank you so much for having me. So I'm going to tell our story, because this is a story more about strategy and need and communications as it is about process and policy.

I started in this job in January of 2016 with Governor Edwards, the only Deep South Democrat governor who expanded Medicaid. I'm an obstetrician. The issue of drug pricing was of note to me as an OB on the area of 17-hydroxyprogesterone, which is a medication, the only medication that reduces repeat prematurity, and because of the very high cost, which was about a 1000 percent increase over what we were able to compound, I was unable to get that for my patients and had created a national quality measure to look at improving it.

So I was aware of drug pricing but hep C came on my radar for a number of reasons. One was that the governor expanded Medicaid, so in July of 2016, we went from a state where one in four people did not have access to insurance to now an uninsurance rate -- of course, that didn't happen immediately -- of 8 percent. So a tremendous shift in our ability to manage population health issues.

And I also was appointed to the National Academy
of Medicine Panel on Affordable Drug Pricing, with Alan and
other distinguished members, and really started digging
into issues of drug pricing.

In approximately May of 2016, I received a letter
from angry constituents in the state not receiving
hepatitis C drugs and demanding access and threatening to
sue us. Similarly, right before taking the job of
secretary I received guidance from CMS saying you must
provide more hep C drugs. Coming into the job, the
governor and I faced a $2 billion deficit. We were at risk
of losing nearly every state general funded program in my
department. And so we looked at the numbers, and even with
the discounts it was daunting and impossible to do what I
thought we should do, which was to cure hep C. There is no
reason why we should have to wait for people to bleed
internally, to suffer, and some to die, to have fibrosis
and then organ damage, to treat a disease that is curable,
and one of the great, arguably, medical discoveries of
recent years.

And so this is very frustrating to me but I
really didn't have the tools to demonstrate the tradeoff.
Lots of policy experts nationally said, "This is a great
What a fabulous deal. Value-based. Look at what a fantastic value this is. You'll save money in the long run." But we don't have a single-payer system, so for me, by the time someone ended up with a liver transplant or the kind of damage it really caused, they're on Medicare.

So I went to the smartest person I knew on this, who is Peter Bach. I called Peter and I said, "Peter, help me demonstrate this." He had developed an abacus of drug pricing, particularly with a focus on cancer patients. But he and I engaged in the first partnership, looking at the state tradeoffs. So we created an abacus that really shows all of the -- and using publicly available information he was able to demonstrate the tradeoffs in state budgets.

And I have a zero-sum game, right. As a state secretary I cannot print money. I cannot borrow from China. It is a crime if I don't balance my budget. So I cannot just go spend money on things, right? I have to cut in other areas.

And so what we showed was to fund what I thought we should do, which was the elimination of this disease, we think we have -- and I'll go into these numbers -- at least 40,000 people with the disease, it would be about $760
million. That is 10 times our K-12 public spend. That would have eliminated our Division of Administration, our correctional system. It would have been nearly our entire university spend for the entire state, and was an absurdity and an impossibility.

So we were able to show that, and to experts, and I started developing a relationship with folks like Jon Gruber, because the Wall Street Journal called me and said, "Well, Jon says it's a great value," and I said, "Well, that's bollocks." And I Googled Jon and called him up and said, "Jon, it might be a great value for you in Massachusetts, but in Louisiana 40 percent of my people are under 200 percent of poverty, we have a $2 billion budget deficit, and it isn't a great value, at least not at a population health level, because it's impossible. We cannot solve the equation."

So I started building a team. So the first step was to show the opportunity cost. The second step was to reach out to Josh Sharfstein, who I knew through the Obama transition, who I call the "public health Yoda." This man is an incredible strategist and with an incredibly lack of need to take credit for things. Anyway, so I called him
and started talking and he said, "Well, what about 1498?"

So 1498 is a federal law, most notably used for night vision goggles. It's when the technology is really in the national interest, whether it's national security or national health. It was threatened by Tommy Thompson in the wake of anthrax threats to reduce the price of Cipro. It really has not been used for health in quite a bit of time. And the idea was the U.S. Government would fairly appropriate the intellectual property and then would be able to then produce that drug.

Arguably, that would be a great value for us in the United States, at the same time of launching this tool, the abacus, called the Louisiana Budget Allocator, I sent a letter to Josh and said, "Josh, why don't you convene some policy experts at Hopkins." And he runs the American Health Initiative, that is funded by Bloomberg. And they convened for two days and really talked about 1498 and what that meant in terms of a policy idea.

And the feedback was incredibly positive. Tons of public comment, tons of positive comments, but PhRMA was hysterical. So within, really, hours of this -- and the Washington Post covered, in a front-page story, some of my
work, and then it was the top bill of Politico, I believe, here in D.C. And so within minutes I had pharmaceutical lobby in Louisiana very concerned about this, right, because nothing gets people more worried than intellectual property and patents, and so on.

And so I said to them, "Well, fine. You don't like this. What do you like? So let's figure out something that works for you." And so a few days later I got a call from John Arnold, right. So the John and Laura Arnold Foundation has done incredible work in the area of pharmaceutical pricing and has funded many of the experts who have done really substantive work in this area. And he said, "How can I help you?" And I said, "John, I need an offensive line. I cannot be the only secretary, and my governor cannot be the only governor taking on pharmaceutical pricing."

And let me give just a minute to why hep C. So hep C, why? Hep C is the leading infectious disease killer of our time. It kills more people than all other infectious diseases combined. We have a registry, started before my time, of 90,000 people who have hep C in our state.
So this was a public health crisis, a public health challenge. And so it was not only about the -- and, actually, for me, really it wasn't about the issue of drug pricing. What I was trying to address, and we were trying to address, and the governor was trying to address, is the fact that we have people suffering, and who are ill and dying. When people in other countries have cure within reach, we didn't, and this was a problem we needed to solve.

So we've always framed it in that way, not can I get a better price, can I save a few bucks. That's not the point. The point is we're one of the poorest states in the nation and we can't afford it, and we should be able to solve this problem for our people.

So I said, "John, give us an offensive line." So he did, and so I had just, at the time, actually, that he called me I was at the NGA, which is a very fantastic organization and it's bipartisan, and they have a health division. And I went to NGA and said, "Hey, could you convene for us a bipartisan group of governors and policy experts, and also bring pharma to the table and also bring payers to the table, and let's try to solve this problem."
And the Arnold Foundation funded that, and that was very helpful because it reduced some of the political heat on us, frankly, and also built a coalition of 11 governors and states who really wanted to solve this problem with hep C. We focused not only on the area of hepatitis C but also the opioid epidemic. Sadly, the prices of opioid treatment are out of reach.

I wrote a standing order two years ago so that in any pharmacy in Louisiana Dr. Gee has written you for naloxone, and the first year 14 people filled it, because it is so expensive. And there was great news this week that there's a new generic and it's $178. And who is going to go to a pharmacy just in case someone they know overdoses, and pay nearly $200 just to have it? I mean, this is just -- so, anyway, so we also focused on the opioid epidemic, because that is also crushing states, but today is not about that.

So we had a very fruitful number of discussions about several models. In the meantime, I continued to work with Peter Bach and Mark Trusheim at MIT. We looked at other models for what could be done. So 1498, not a possibility. What else? So the question to the
pharmaceutical industry and then started to become a partnership with them was, okay, 1498 is a non-starter. What can we do? You see our budget. You see the situation. You all know, in 2014, because of the new and ground-breaking drug, Sovaldi, Medicaid paid 24.3 percent more for drugs. So every state was feeling the crunch. But tell us how to solve this problem.

So the NGA process continued, and in the meantime there really wasn't a lot of traction for this discussion until Mavyret came out. So when AbbVie came out with a competitive drug and in this space of a cure there started to be some competition, then we got somewhere. So the drug companies have come to the table and are very enthusiastic about this. We've had public comment. We have released our RFI, which you can see, responses that were very -- in August, finally, after we realized that we did have some will to achieve a subscription model, which then was the best policy solution that was identified, which was really a win-win for pharma and for Louisiana, and I think was arrived at because of a number of factors. One, that there was a competitive space, and so companies liked the idea of -- and we can get into this later -- they liked the idea of
a subscription model in the area of a drug that cures, because, by nature, something that cures over time has a diminishing graph line. And a subscription model is flat, right. So we can guarantee a number of years of guaranteed spend. Drug companies get good PR, which is, of course, an increasing issue in this country, the fact that prices are really impacting the public's health and impacting access, and the public is getting that, and so our legislators, and so are states.

And so I think this was really a perfect solution in that the companies like it because they don't lose money. And our argument was, "Listen, we also need to mention focus on corrections, because Louisiana is the number two state in the nation, highest number of incarcerated people," and we didn't want to ignore that we had potentially tens of thousands in corrections and not treat them, as 90 percent of them get out. And so if we want to cure hep C we have to deal with corrections. So that's been a part of our model.

So where we are now is negotiations with CMS are continuing. They're very positive. The Trump administration has been fantastic to work with on this.
The companies have publicly expressed their enthusiasm and have been working with us. United Healthcare, Centene, and others have publicly commented. There is a path forward, and both PhRMA and Gilead mentioned in their public comment the supplemental rebate program, which is a known -- of course, the biggest barrier is Medicaid best price, so companies don't want to enter into an agreement with a state when they interfere with Medicaid best price and then impact their entire national, as well as potentially global markets.

And so we have a number of work-arounds, 340B and corrections, supplemental rebates in Medicaid. We thought, initially, we were going to have to do an 1115. We don't believe we -- nor does CMS, has CMS indicated we need to do an 1115 waiver.

So we are full speed ahead. We have also engaged funders on the public health infrastructure and complete re-imagination of how we treat hep C, because if the goal is not to treat people once they're sick but to treat everyone, that's a complete public health transformation, and we have focused on that. We're already -- we've
already -- we are very close to receiving funding to do that and already have a public health strategy in place and have been working with federally qualified health centers. What's also beautiful about this is Senator Cassidy, one of our two Senators, is a hepatologist, has been supportive. His nurse is going to be one of our coordinators for this work, which he worked with in the charity system.

So we are full speed ahead. I think the policy details are interesting, but I think more interesting is how this came about, which was a variety, I think, of messaging, politics, and then a competitive market that led to companies wanting to find a new way to fund. So we're very excited about the potential and how much this can improve the health of our state.

* DR. JEFFREY: Good morning. Thank you for the invitation to be here today. My name is Paul Jeffrey. I'm the Director of Pharmacy for MassHealth. I've been in that position for 17 years, so I have a lot of battle scars from that, from being in that job, but it's been a very positive experience.

I'm going to talk a little bit today about our attempt to get a waiver from CMS from some of the
constraints that we felt were holding us back a bit, and
also talk a little bit about a way that we've decided to
handle new-to-market, very expensive drug therapy that's
administered in the hospital.

So just -- I won't spend more than a minute on
this slide. MassHealth, Massachusetts has been fortunate
to be, you know, able to create some health care reforms
over the years. In March of this year, we transitioned 1.2
million members in our plan into an ACO model of care,
which I think, among other things, stamps our commitment to
value-based payment structures for health care.

The system is relatively complex and I won't get
deep into it, but any member in the Medicaid program who is
eligible for managed care, in one stripe or another, will
be enrolled in an accountable care organization, or in one
of our remaining managed care organizations, which we have
shrunk dramatically since we've implemented. The balance
of our members typically have other insurance. So we have
about half a million members that have other primary
insurance.

This was launched in March. It was quite a
heroic effort to stand it up and then, likewise, to
transition all of our members into this process, and we're about to go into year two starting in a few days.

So we requested a waiver that has been essentially referred to as the closed formulary waiver, by both advocates and detractors from the concept. This timeline, I'll only reference the fact that when Secretary Price came forward with a proclamation about HHS offering flexibility in certain policy decisions at the Federal Government level, we thought that that might be an opportunity to suggest something that was certainly out of the box. So we huddled locally, internally, and we created this concept that we would like to get some relief from the Medicaid governing rules in order to operate a closed formulary.

And maybe, in retrospect, that terminology was problematic. That said, we went forward with our process, and we submitted our state plan amendment in draft form. Once the draft form hit the phones rang off the hook, so we had a lot of interest in this waiver, and spent many hours talking with stakeholders about what our intent was, including, of course, CMS.

When the President's blueprint came out and
offered an opportunity for an exemption from the Medicaid Drug Rebate Program for five states in the demonstration project we could kind of project that that was probably the death knell for our waiver. All the same, you can imagine the challenge of stepping out of the Medicaid Drug Rebate Program. Massachusetts, last year, collected $910 million of rebate, so it would not be rational, of course, to put that at risk, so we certainly didn't do that.

Once we got the denial from CMS, we retracted some of our local legislative initiatives because they were hand in glove with that CMS waiver request. So we're back to the drawing board, and I'll tell you a little bit about what we're looking like today.

So the background is that our spend in pharmacy has doubled over a very short period of time. I spent a lot of time looking at the pharmaceutical pipeline. The trend is expected to continue. The drugs in the pipeline are alarming in terms of their cost, but sensational in terms of their clinical efficacy, and the science is mind-bogglingly brilliant. That said, though, how are we going to accommodate that even in a state that's relatively well
heeled, like Massachusetts? The numbers were pretty scary.

So we have made best efforts to maximize our rebate opportunities under the current structure. However, there are some limitations to that. Some of them are local. So, for example, we have to procure supplemental rebates in our state system using the state procurement rule that we would use for procuring other contracts or bathroom fixtures, you know, so it's the same process, which is exceedingly difficult from an administrative burden. So we're looking for relief from that as part of our local legislative package.

And then, of course, we don't have the ultimate hammer, which would be if the manufacturers refuse to negotiate, you know, if we walk away from the table, then we could say you're not on the formulary any longer. And that was the tool that we were looking for in the waiver.

Let me say at this point that it was never our intent to deny access to drug therapy, never, not for a minute. So, of course, convincing people of that, particularly the advocacy community or stakeholders, PhRMA, patient advocates, became a hard sell. But that was not our intent. Our intent was to be able to negotiate a
value-based cost, net cost for the drug in our program.

So these steps one and two were locally. We proposed this to our legislature, which was taken back when we lost the waiver approval. So we will essentially continue with this strategy to request ability to directly negotiate with manufacturers in a much less burdensome process without going down the rabbit hole. The opportunity for supplemental rebate, just your standard market access supplemental rebate in the Medicaid program, dries up in about a year, just the way the market works. So if we're not on top of it right away, then we're going to forgo the best opportunity there because of Medicaid best price and the negotiations with manufacturers in the commercial market, the rebate -- you know, we get the advantage of that rebate, but it's two, three, four quarters later. So there's a year of opportunity lost there, and we've calculated that to be not insignificant. So we intend to move forward with identifying a cost-effective target price. We'd like to use independent third parties to help us with that. A local neighbor of ours is ICER, so we've done a lot of thinking around this using either ICER's work or direct discussions with ICER.
There are some limitations to that. It would not be the only approach that we would use. The disability advocacy community is not in favor at all of any kind of reference pricing that uses qualities, so we're going to have to accommodate that in our thought process. And, of course, we would intend or envision having outcomes-based arrangements as we move forward.

If we fail to -- if we propose a target-based price to the manufacturers under this new structure and they fail to meet our target after a negotiation, then we would, if we have the authority, subject them to a public process for justifying their pricing, and that is in the weeds, if you will, in terms of how that would look and who would do that in Massachusetts. But that would be the intent. And then if the manufacturer fails to move, we would give the state authority to sanction that manufacturer in some way as yet to be determined, but we have some thoughts on that, of course.

The third part was the CMS waiver piece, and that's where we asked for the ability to determine that a drug would not be on our formulary if we couldn't meet agreement in our step one and two and/or, excuse the
terminology on the slide, no proven efficacy, it would be relatively so. And we have also taken some criticism around our apparent targeting of accelerated approval drugs. That is not -- that is somewhat warranted, drugs that are coming to market under an accelerated approval. They're still approved, are FDA-approved products, but reading in the product literature, you know, you can -- in the product labeling you can see that efficacy is yet to be demonstrated. So we want to make sure that we can bear the -- have a process for bearing the cost of that over time.

And then we would have additional guardrails to help protect our members should we engage in this kind of a negotiation around formulary exclusion, which, again, now is off the table and we won't be resubmitting on that.

So I'm going to switch with the last minute or two I have to talk about a payment strategy that we have embraced for new-to-market cell and gene therapy. These are the -- first to market was Kymriah for acute lymphoblastic leukemia in kids. It came with a guarantee of performance right out of the chute, and that caught our attention, of course. So did the $475,000 price tag. And now there are three such products in the market, at least
in our categorization, Yescarta the second and Luxturna for genetic blindness the third. If those drugs are administered in our inpatient hospital environment, they would be paid under a bundled payment, for lack of a better term, based on a commercial product that was adapted in Massachusetts. So we call those the inpatient payment, an adjudicated payment amount per discharge.

In that methodology, a $475,000 drug charge absolutely distorts the methodology. So running our numbers, we made a determination that -- and we now have some evidence of what might happen, but let me make the point. We made a determination that that distorted our methodology, so we wanted to carve those drugs out of the methodology. So as we walked through this, there turned out to be numerous benefits to doing that, not the least of which is we wanted to be able to monitor these patients, particularly if there was an outcome-based arrangement.

The Kymriah deal is with the provider, the hospital, not with the payer. So we had no way to really directly monitor that, nor could we comply the hospital to sign up for the outcomes-based agreement.

So one of the things, we got a fair amount of
interest on this model from the pharmaceutical industry because they see this as something that would allow the industry to work with the payer in an outcomes-based arrangement, maybe differently than with the provider, which is essentially what the Kymriah deal looks like.

So we asked for and received through a state plan amendment authority to carve these drugs out of our bundled payment in both the inpatient and the outpatient setting. Curiously, in the outpatient -- in the inpatient setting, if the drug's carved out of a bundled payment, it makes that drug a covered outpatient drug, making it eligible for rebate. So that move in and of itself would ostensibly save 23.1 percent for newly marketed, very costly drug therapy for the Medicaid program. And that's one of the reasons I think we're getting a lot of questions about that, and also because of the industry's interest in ways that we can negotiate arrangements around outcomes-based or performance-based deals, if you will, contracts with the manufacturers for these drugs.

So I'll stop there. I'm at my time. Thank you.

CHAIR THOMPSON: Great. Thank you, Dr. Gee, Dr. Jeffrey. That was extremely helpful. I know a bunch of
Commissioners will want to jump in and ask you questions. I was particularly struck by both of you talking about the journey and the kinds of things that you were thinking about and contemplating and the reaction from pharmaceutical manufacturers, from beneficiaries, from advocates, and so forth. So I think that's very helpful for us to kind of take into consideration as well as we think about any particular recommendations that we might make to the Congress or to the administration.

I want to pick up on a couple of points. Dr. Gee, you talked about spending some time supported by the Arnold Foundation talking with a variety of other states. A couple of points I wanted to ask you to expand on. One is you mentioned the idea that hep C particularly, that the savings associated with providing that cure are really delivered to other payers, not to Medicaid. So I would love for any conversation that might have been had about how to recapture that value chain, like is there a way to quantify that? Is there a way to capture that back if Medicaid is making -- we've talked about this in this Commission a couple of different times. If Medicaid is making an investment when people get really sick or when
people can’t work and they are returning to work or they are coming into another payer healthier and without needing some of those investments, is there a way for us to quantify and think about how Medicaid can get some kind of recapture?

And then the second is that just in terms of thinking about the subscription model that you’re looking at now, whether -- what the discussion has been about best price. That has also come up in our conversations before, and just whether or not you think that Medicaid best price does more harm than good or not. Any comments on that?

DR. GEE: So in terms of other states and capturing savings, I think part of the importance was to ask for writing a new equation, right? So we can’t solve the discount equation, so I think part of the value of that discussion was bringing states together. Our goal is a population health one, which is to eliminate an infectious disease. That’s very different from approaching it from a standpoint of what additional discount can I get, how good can I do, right? A very non-transparent process. I used to be on the advisory committee that approved the formulary, and I wasn't even allowed to see what the price
was, right? So that whole -- so we're not addressing all
of those issues, but we're addressing the value proposition
for the American people, which is that the U.S. produces
and does the large lion's share of the intellectual
investment in these cures, and then the American people
don't get to benefit from them. So how do we solve this?

So I think that that was a really valuable
discussion, and, of course, PhRMA, I want to highlight how
engaged they were and how helpful they have been. So all
three companies that produce these drugs were engaged, have
been supportive, and have been at the table, which I think
was very important to our being able to get to the point
that we are now.

So in terms of long-term savings, we have
certainly talked with CMMI, had great conversations with
Adam Boehler and others about Medicare savings down the
road and how you could leverage that. I certainly think
that that's applicable in other areas. This is such a
large problem for us that we have 100,000 people nearly on
our registry. We think probably the number is 200,000.
We're looking at dealing with corrections. And so the
number, if you looked at -- but when we look at a year
savings for Medicaid, so Peter Bach's Abacus tells us that looking at our own Medicaid claims data that only about $600 a year would be saved by the treatment. So if you look at churn and how long people stay in Medicaid and so on, you know, that value proposition may not be there. So we've had discussions, but this is a daunting -- you know, there's so many people. I think that conversation's probably more applicable to conditions that are more rare. And I think it's an important one to have, a very valuable discussion to have. And we certainly also even thought about veterans, right? So we have lots of incarcerated veterans. Wouldn't Veterans Affairs have an interest in us treating incarcerated veterans with hep C because they'll save money down the road?

So I think these are really important discussions, but there was no quick fix at CMMI, and we have both -- we have lots of pressures. I think one of them is that PhRMA's willing to come to table and has publicly expressed enthusiasm. So we don't want to lose that momentum. And so these conversations are important and will continue to happen, but we decided not to go that route.
In terms of best price, there are a variety of work-arounds. I'm not a pharmaceutical pricing expert, so I don't know if I can give you an answer. What I can say is that I think that our recommendations from the National Academy of Medicine Affordable Drug Study were very powerful. Very few, if any, have been implemented really at a systemic level. I think we should start there. Really, if something doesn't work or doesn't provide value, I ought to not have to pay for it. I think we had a look at subscription models -- you know, we ought to promote the pharmaceutical industry looking for cures because, unfortunately, the economic model for a cure is not in the long term very good, and so I think the subscription model is a way, an interesting way to look at how you can sustain and have a predictable income from those medications.

I do think, you know, certainly the 340B program, which you're going to be talking about later, is a work-around. Supplemental rebates are a work-around. So we have work-arounds to best price. The issue is that the drug companies typically are not motivated to use those work-arounds or, you know, certainly not at a population level, and I think if we are able to use this in
corrections, this would be, to my knowledge, in terms of hep C, the first state to really look at the entire correctional population and treating them. The idea of this is to take the spend we have, because the other argument is we're not going to have more money. Louisiana is not going to come up with another $200 million, and so why do you care, pharmaceutical industry, if we treat everybody -- we do have an opioid epidemic that I didn't mention, so we've seen a great increase in the number of hep C, so this condition will be alive and well for a minute, and so let's not worry about, you know, the meta goal, which is complete cure on the face of the Earth. So there should be ongoing profit. But let's solve a problem now, and I do think certainly best price was a substantial impediment and early on seemed near insurmountable, and we do go to CMS and say can we waive it, and they said no, just can't waive it. So I do think that that is an important consideration for you all.

CHAIR THOMPSON: Thank you very much.

Dr. Jeffrey, the question I wanted to ask you was kind of building on your point about not wanting to put the entire savings associated with the Medicaid rebate program
at risk. Is there -- which I think is right. Most states are not going to be willing or able to do that. Even if they think they have a set of creative ideas or some alternatives, that's a lot to place at risk.

Is there a percentage of that that could be placed at risk? In other words, if you contemplated a situation in which you were granted more flexibility for maybe some smaller percentage of rebate, is there some room in there between all or nothing to be able to have some maneuvering room that you would want to exercise that you would be willing to accept?

DR. JEFFREY: So thank you for the question. I'm not sure how I'd structure -- or how we would structure such a thing, but we would want to be open to any alternative arrangement that we would think would be to the best benefit of the commonwealth. I'm not sure how I would see that occurring. So I'd like to -- you know, the wheels aren't putting together a model here yet. So, yeah, we would put -- we would obviously be willing to put something at risk if the return on that investment would be in the best interest of our members and the state. So the answer would be yes, but what proportion or how we would make that
I really haven't conceived of that.

CHAIR THOMPSON: And your experience in trying to seek a waiver from CMS, was the response back about legal authority or about a view on the design itself?

DR. JEFFREY: Deep breath. So we still don't know why we were denied, you know, and you can find several authors who have written pieces about that, Rachel Sachs and a few other people who have -- you know, in the New England Journal perspectives. We got a no, but we didn't get a reason why we got the no. So I'm not exactly sure I can answer your question about why it didn't work.

So we spent a fair amount of time speaking with CMS casually, informally, and with the stakeholders, but, you know, upon release of the waiver draft, literally the phones rang off the hook, the congressional delegation, the advocacy community, PhRMA, PhRMA, PhRMA, and so there was a lot of pressure, I think, to say no, frankly.

CHAIR THOMPSON: Okay. Stacey?

VICE CHAIR LAMPKIN: Thank you both. This is fascinating. We've been talking a lot about managed care service delivery models and oversight of those models, and I'm curious. I would like to hear how you are
incorporating these pricing innovations into your managed care programs or not. Have you carved out the hep C drugs so that you can run the subscription program? How are you thinking about this in that service delivery model?

   DR. GEE: Sure. So we thought about a variety of ways and the comments, the response to our RFI suggested a variety of ways, but -- and at some point, managed care companies came to us and said, "We'd like to do our own subscription model. What do you think?" Our concern of that is if you break it up into too many segments, the companies are just not going to be motivated. What's motivational to these companies is they get a large population, they get a sustained income, and it shouldn't be much of a decrease, or maybe a slight increase over their market share. So I think that -- you know, I think that's a really important point.

   So in terms of managed care, you also don't want -- people with hep C have lots of other conditions that are important to treat. They have mental health issues, so totally carving out the person didn't seem to make a lot of sense. So where we are now is to think about carving out the spend just for hep C drugs, and that seems to be the
most plausible.

DR. JEFFREY: So we are working with a number of different structures, again, without getting too far into the weeds about how we compensate our managed care partners, all of which are essentially rewarded or penalized, if you will, based on the total cost of care for the population of patients that they manage. But, you know, there are many different approaches to that.

So, for example, if we enter into -- we have a market access agreement for hepatitis C therapies, and we've chosen three preferred products. We mandate them to the managed care organizations that they must follow our preferred drug list for that therapeutic category down to the level of using the same criteria for reviewing any request for the drug. And we've done that in several therapeutic areas, and we would contemplate doing that -- for example, if we ended up with an outcomes-based arrangement, we would make a determination whether we keep that within the historical fee-for-service population that we manage or impose the same requirements on our managed care population.

It's likely that the better arrangement in terms
of clarity of what the state's purpose is and how
prescribers should respond or providers should respond to
our intent to have a universal policy. But today we're
doing that on a therapeutic class basis. So if we enter
into a -- however, let me talk about the carve-out for --
we have not imposed that requirement on our accountable
care organizations or our managed care organizations to do
the same. So the way we would -- the lever we would use is
in risk corridors or exceptions from the total cost of care
calculation. So our hepatitis C drugs are carved out, so -
- virtually. The managed care organizations still manage
it, but there's a separate financial accounting for that.

CHAIR THOMPSON: Maybe it's a little bit of the
same thread, although in a different direction. One of the
other things that we've talked about in this Commission is
the way in which Medicaid compares to commercial payers in
terms of how purchasing happens, how oversight happens, how
utilization review happens, how management controls are
deployed.

So could each one of you talk a little bit about
the extent to which you engaged in conversations with other
payers in your state or region around some of what they're
doing? I'm struck by both some of the conversation around you need to have a certain amount -- and we've talked about this before, too, even in terms of purchasing pools -- how much volume do you have to have and do you have to deliver to a manufacturer in order to get the concessions that you're looking for and create the kind of partnership that you're looking for. So I'm just wondering where the commercial payers may have played in the conversation in terms of either lining up or aligning or coordinating or not being a part.

Dr. Gee, could you start off?

DR. GEE: Sure. This is not answering your question, but a point I think is important to make, is one approach we could have taken is to go with a company to CMS, right, the waiver to the agreement.

What we are envisioning, which I didn't describe, is a transparent competitive process. So either RFI, respond to RFP response, which should be -- we envision depending on our process in terms of our division of administration and RFP approvals to go ahead in the next month. So that is, I think, the best way. I think it's best for us. It's best in terms of the companies and the
timeline that we were looking to achieve.

CHAIR THOMPSON: Thank you for that verification.

Thank you.

DR. GEE: So then in terms of the private -- so
one of the first conversations we have, so Louisiana is a
predominant Blue Cross Blue Shield market. We have a great
relationship. They also oversee one of our Medicaid health
-- or have a relationship with one of our Medicaid health
plans, an interest in it, and so went to them and said --
and others have envisioned if you really want to eliminate
hep C, surely you would want the entire population of
Louisiana in a model and a population health model.

So a couple things. One is Blue Cross had looked
at their own data and said, "We don't think we have as big
a problem as you do." I mean, our problem is really in
corrections. We treated about 0.5 percent of people in
corrections last year or maybe fewer, probably fewer. In
Medicaid, we treated about 3 percent of people. So we are
not nearly where we need to be.

Blue Cross looked at their data and said, "When
we look at the time trend of number of people treated
getting in, we don't think we have as big a problem. We
can accommodate," and certainly, they can raise their rates, right? So if the costs go up, they can raise their prices. We can't. They've been able to accommodate in ways that we haven't, and we also were concerned that bringing in Blue Cross into the discussion would be jarring to the pharmaceutical industry and threaten their relationships across the nation. What we're really trying to do is get a workable solution as soon as possible and didn't feel that bringing Blue Cross along was necessary.

There's been a lot of interest. Other states have private insurance markets call, I have had calls from North Carolina and so on saying can we learn from this. I don't know that it's as compelling.

And also, just to reinforce, although there is an opioid crisis and the rates are going up, the population of people that have hepatitis C tends to be lower income, very high corrections reservoir of people who are infected. So it's a little bit different problem and higher barriers for Medicaid agencies than for a Blue Cross Blue Shield.

DR. JEFFREY: I'm not aware of any formal conversations with our commercial payers in Massachusetts. They likely occur on an informal basis, if you will.
However, all of our managed care organizations today have commercial lines of business. When we discuss matters related to pharmacy policy, just on my level, at the director pharmacy level, I'll get a reflection of "Well, we can do this for the managed Medicaid plan, but I have to take some consideration for what that means to my commercial population."

Let me also make reference to the fact that there are some efforts to put the commercial payers and the Medicaid program together. They are at the talking stage now through a program at MIT. You may be familiar with their NEWDIGS FoCUS program, but it's a think-and-do tank to try to create solutions to high cost or high-investment medications. And there's a proposal to have an outcomes milestone-based arrangement that would include a group of commercial payers, and they're trying to get the Medicaid program involved in that process.

You asked about utilization. Utilization to me is an entirely different story in the Medicaid population. We do not have the levers that the commercial plans have in terms of essentially co-opting the members in the process by out-of-pocket expenditures. So a commercial payer will
leverage the utilization of pharmaceuticals based on co-
insurance, copays, and things of that nature that we have
no access to. We do have nominal copays in Massachusetts,
but less than half of our members actually pay a copay
because they're exempt in some way or another, and the
maximum copay is $3.65. So that becomes important to a
Mass Health member who has 12 medications a month; however,
unlike a commercial plan, I'm not going to be looking at
$100 copay for a brand-name drug and ask my doctor to
prescribe me a lower-cost copay drug. That's not going to
happen in the Medicaid program.

We use a lot of prior authorization in the
Medicaid program for pharmacy, a lot. We're not always
very popular with the prescribers, as you might imagine.

DR. GEE: Just one additional point, we
considered the uninsured population in Louisiana. Of
course, the Medicaid expansion has reduced that
dramatically, but the irony is often uninsured people are
better off when they have hep C because there are patient
assistance programs that make the drug affordable. If
you're incarcerated or on Medicaid, those programs are not
available.
So although we care about folks who are uninsured, we really focus on getting people covered, and patient assistance programs is our solution for them.

CHAIR THOMPSON: Thank you.

So just reflecting on some of the things that you found to be easier, harder, possible, impossible in terms of thinking about the federal statute, any advice to us about places where we should be looking hard at recommendations around changes to Title XIX, to the rebate program and the way that it operates, the flexibility that states have, the places where we should be looking to carve out or change or make refinements, so that you can adopt some of the practices that you're looking at?

DR. JEFFREY: Let me just get this out, off my head, about tinkering with the rebate program.

The pharmaceutical industry in this country is anchored in a rebate-based method of payment. The average payment by a payer in the United States is at 52 percent of the list price of the drug. So we are playing with more than 50 percent of the money that's moving around here in a discounted program through a rebate structure.

I would be cautious about which levers get pulled
there and what the unintended consequences of that are, and
I think that pharma is likely to win, no matter what the
model looks like, unless we impose some kind of price
controls. I'm not advocating for that; however, if there
isn't that limitation, then what's to stop the
pharmaceutical industry from charging the cost, the price
that they want, one way or the other?
Of course, all the rebates are baked into the
launch price, as you well know. Just a cautionary tale
there from my perspective.
CHAIR THOMPSON: And so your point, Dr. Jeffrey,
there is simply that you can move a number, but it's going
to get made up on this other end?

DR. JEFFREY: Absolutely, absolutely.
I think that there's opportunity. I don't know
that it will bend the cost curve, but I think that states
need greater latitude and flexibility in crafting outcomes-
based arrangements.
We do have a green light from CMS to engage in
such arrangements today. I think that some support in
terms of what we determine the value of medications is from
the federal level would be very useful. I know that that's
a third rail, but just saying.

CHAIR THOMPSON: While we're spit-balling.

DR. JEFFREY: Yes, exactly.

[Laughter.]

DR. GEE: So, I mean, it's a very complex and nontransparent system, and so you push -- it's the whack-a-mole. You whack one, and then another one pops up.

I think importance about transparency, it needs to be full. If we have transparency, but it gets in the way of our rebate program, that's a problem.

I would again suggest the National Academy recommendations. I think that that's a great start for you all.

We found a work-around, we believe. Right now, we don't think that the federal structure in terms of best price is an impediment to us, but I do want to suggest that we need a greater focus. And I think a great example of a work-around that's benefitted the public, to a great extent, is the Vaccines for Children program because that's an area where access was a problem, and we have a new way of delivery that's been very successful in Louisiana. It's one of the few things we do great on in terms of public
health is getting kids vaccines. I would suggest that you all should focus in these areas.

There are areas, the access to prep, HIV treatment, hep C, treatment for opioids. We can't afford it in Louisiana; for example, methadone. And we can't afford to get naloxone in the hands of first responders because of price. We can't afford to eliminate hep C. So I would suggest that we don't get in the way.

We also don't want to disincentivize cures. Sovaldi was a fabulous thing that gave many people hope. It's a tremendous innovation. I've been very thoughtful, as we've gone on this journey, not to try to disincentivize future cures. That's not what we want to do. So how do we solve these problems in a way that's a win-win, but makes sure that the people of this country have access to cures and we can solve public health challenges?

And there is real brokenness there. There's brokenness in terms of the research that gets done, because we don't do research in areas that aren't lucrative -- sickle cell disease, contraceptives, vaccines even. The Zika vaccine got dropped by Sanofi because a variety of reasons, but that's disappointing because it's coming back
in Brazil. And it may come to me next. So we've got to have -- I think there is an interest for more governmental role, greater governmental role in areas that are really important to public health, where the public suffers and/or costs go up.

There's a lot of anger in this country about health care costs, and in my state, a lot of the anger is directed at the recipient, the people, the fraud, "The individuals who have Medicaid, by darn, and they don't deserve it, and let's get them off," instead of really where we ought to focus is, Why in the hell is health care so expensive, and what are we doing about it? And why can't we afford -- why are we paying so much for things the taxpayer has to pay for?

In the area of Blue Cross, they can raise their rates, and unfortunately, individuals have to pay for it. The rates go up; the taxpayers of Louisiana have to pay for it. so I think that those are areas where there's population health interests that you all ought to be involved in. We absolutely need intervention, I believe, but I cannot be at the death of innovation. And those are important conversations.
What I don't like about the pharma argument is
"You take a dime from me and innovation comes to a halt, and it just completely stops." That's ridiculous. But there are important arguments that they make that we have to be conscious of.

DR. JEFFREY: May I make one -- a couple things jumped into my mind.

CHAIR THOMPSON: Absolutely. Yes.

DR. JEFFREY: One is I have some concern about accelerated-approval drugs that come to market for which the total proof of efficacy is lacking; however, they do get approved.

My concern is that not every manufacturer completes the requirements for demonstrated efficacy of those drugs. So the performance on post-marketing surveillance to fully flesh out the label is poor, maybe in the 50 percent ball park.

I think the one thing you might contemplate is making an arrangement or allowing an arrangement where manufacturers are held accountable to Medicaid programs relative to maybe an enhanced rebate during the period of time until they demonstrate efficacy or a penalty if they
don't, something to that nature.

Another area that I think is perplexing is the genetic therapies that are curative. If you've been paying attention to the news blogs, AveXis is coming to market with their spinal muscular atrophy drug, and they're talking about a $4 million cost.

So just contemplate that for a moment. How do you fit that into your budgeting? For commercial payers, we're offering amortized payments or something like that, but that may not work at all for a state, because we may not have a structure to enter into a deal like that. You might not be able to solve that at the federal level, but some careful thought into -- in the pipeline is replete with these curative therapies or near-curative therapies that are going to be costing multiples of a million dollars. So that seems to be an important threshold, I think, that gathers attention.

How are states -- what guidance can we get from the federal government about how to finance these? What does that look like in the Medicaid program? We struggle with this, and we're going to be seeing these drugs during calendar 2019. We'll see our first million-dollar drug,
truly million-dollar drug.

CHAIR THOMPSON: Thank you.

Let me just take a look and see if any of the other Commissioners -- Peter.

COMMISSIONER SZILAGYI: This is really excellent.

Thank you.

Dr. Gee, could you just explain the subscription model? I think I'm missing -- are you promising that a higher percentage of patients were going to get the medicine for a lower cost? Is that sort of the bargain, or can you describe that?

DR. GEE: Yeah. The idea is that we take our spend now, and we do an RFI or RFP and say, "Hey, company, we spent X." Let's say it's $35 million. "We'll give you that or less, and we get unlimited access." And so the company is guaranteed to get that, and then at a certain point, we get 100 percent rebate after we go over that. So that's the idea.

And then in corrections, it's a different process. The correctional -- what we have in Louisiana in corrections is a relationship between the 340B entity and the correctional facility, and so it's a little more --
you're not talking about the -- in 340B, you don't run into best price issues, and so then you're able to come up with an overall price and that correction spends. And so the idea is don't increase our spend that we have now, but get near unlimited access.

CHAIR THOMPSON: Darin.

COMMISSIONER GORDON: So when you talk about you calculate what you spend on it currently, I am assuming in the Medicaid program, not taking into consideration, as you acknowledge, that in a particular case of hep C that some of the higher expenses are in later years -- and you talked about step one in your process, external evaluation of cost effectiveness. So, in both cases -- and that since you are trying to reevaluate the value of the curative agent as opposed to defaulting to how the pharmaceutical company is determining the price, the value, that is, from a cost perspective -- and yours is really clear, "Here is what we spend today. We will continue to commit that, and if it goes over that, then it's arbitrary."

Help me, on the Massachusetts side, understand.

I see that you'll have third-party independent analysis.

You'll have this, and then you talk about negotiating with
them. Does that come in the form of a special supplemental rebate? How are you coming back to the value in which your third party is calculated?

DR. JEFFREY: Thank you.

Maybe an exemplar would work. So drug A costs the manufacturer's wholesale acquisition cost is $400,000 per treatment for a year, something like that.

Using internal processes as well as external parties, let's say ICER and perhaps some other threshold, value-based evidence, value-based model, we calculate that that drug really should be priced at $200,000.

So we go to the manufacturer and we say to the manufacturer, "If you want access to our formulary and we've been negotiating what the terms of that looks like, what does the pharmacy benefit look like there, we believe the price should be $100,000 -- I'm sorry -- $200,000. You need to commit to us 50 percent rebate." And that's the point of jumping off for the negotiation.

Let's say in that model, we take that to fruition. We still are going to be obligated to cover that drug under the covered outpatient drug rule and the Medicaid drug rebate program. However, we would then take
a step to refer that manufacturer to a deliberative body for the purposes of examination of their pricing strategy, and we would make that a public process, justify why you do that. You've seen this in other states.

Ultimately, if we follow the strategy that we proposed last year, if the manufacturer fails to meet our threshold pricing, they could be subjected to penalties, statutory penalties that would be issued by the Attorney General, for example, "This drug should be $200,000. You have an unfair business practice. I'm going to fine you $200,000 for every patient that gets this drug." Again, hypothetically and wildly. It will not be anywhere near as easy as it took me those three minutes to explain.

COMMISSIONER GORDON: No. Thank you. That was very helpful in just conceptualizing how those models will work.

One other question, and you talked about how sometimes when these drugs are going through the FDA, the efficacy, the evidence behind the efficacy is not as developed, I guess, when they're in the fast-track path. But even if there's situations like when we saw this with hep C, where the evidence that was submitted to FDA showed
effectiveness at a certain fibrosis score, yet when it went
to market, there was the encouragement for coverage beyond
what evidence was submitted to FDA.

How do both of you all -- when you think about
these high-cost therapies, how often do you track back to -
- and do you feel you have sufficient time to track back
to, as you set up your criteria, coverage criteria, the
evidence that was submitted as part of the FDA approval?

DR. JEFFREY: So as we go through our process of
determining how we're going to manage the drug, of course,
we do a -- well, not of course -- we do a very
comprehensive review of the literature as well as what the
labeling says. And there are many examples of accelerated-
approval drugs, as you described. I could name three or
four off the top of my head. So we may make a
determination that we would manage the drug to label, or we
may manage the drug to the clinical trial evidence that got
to the label.

So Radicava for ALS, you know, was demonstrated
in the clinical trials to be effective in a particular
population of patients. The label came out and said that
any patient with ALS should have access to Radicava. So we
make a determination of whether we would want to manage
that drug to label -- anybody with ALS has access to it as
soon as they demonstrate the criteria that they have ALS --
or we could get refined and go down to the specifics of
what the clinical trial data. And that's a drug-by-drug
decision process.

DR. GEE: So, Darin, you've been to my office and
you've seen our Medicaid staff. We may have four full-time
pharmacy staff, okay. So what Paul has in Massachusetts,
he has the University of Massachusetts, he has more smart
people he can shake a stick at. Not that we don't have
smart people. We don't have lots of policy experts,
particularly in the pharmaceutical sector.

So we don't do that. We have a supplemental
rebate vendor. As I mentioned, even as secretary I often
don't get access. I'm allowed to see it but the committee
that decides whether something is of value can't even see
what the price is they're supposed to be agreeing on. It's
not a system that's reflexive, and certainly our hep C
work, from the very outset we are hopeful to obtain funding
to have Rena Conti and Jon Gruber evaluate our process, and
we're being very thoughtful.
I would correct maybe what you said about our value proposition. We're not actually litigating the issue of the value of this drug. We're saying this is what we can afford and that's it. So it's a little different.

COMMISSIONER GORDON: [Speaking off microphone.]

DR. GEE: So it's a little different.

COMMISSIONER GORDON: Purely on the cost.

DR. GEE: Yeah. Yeah. But we don't have the resources to go look at was this value or not. I think that's something that might be of interest to you all, to think about how you can help states measure value and effectiveness, and we don't even look back at what the percentage of care was. Certainly if we entered into a value-based rebate agreement, or so on, we would want to look at that. Oklahoma is there in some ways, but we're really very nascent in those discussions.

COMMISSIONER GORDON: [Speaking off microphone] - - is what I'm saying, from a cost perspective, determining what the Medicaid entity is currently spending on that population, and that being a determining factor for the pricing of that particular agent.

DR. GEE: But we're not saying that they're not
the value of the company. Maybe they are the value of the company. But our point is we can't afford that value.

CHAIR THOMPSON: Okay. Let me go for one more round, making sure I'm not missing anyone. Dr. Jeffrey, Dr. Gee, thank you very much for being patient with us and letting us keep you past your time. We could probably keep you here for quite a bit more, but we'll call a halt at least to this part of the conversation.

What we're going to do, just because we're a little bit behind time, I'm going to go ahead and call a break now. We'll come back in 15 minutes, at 11:00. We'll take public comment before we begin our discussion, so that if any members of the public want to add to the points that have been made by our panelists, or respond to any of the lines of questions that we've had here, as Commissioners, you'll have an opportunity to do that. Then we'll have a little bit of a Commissioner conversation before moving on to other topics.

Dr. Gee, Dr. Jeffrey, thank you very much. This has been extremely useful. We really appreciate you taking time out to spend some time this morning with us.

DR. JEFFREY: Thank you for the opportunity to be
here. We appreciate it.

[Applause.]

* [Recess.]

CHAIR THOMPSON: All right. I'll give the 15-second warning here for wrapping up conversations, and then we'll turn to our discussion period.

[Pause.]

CHAIR THOMPSON: All right. First let me invite, as I promised before the break, an opportunity for any public comments.

### PUBLIC COMMENT

* [No response.]

CHAIR THOMPSON: That was a good fake there.

[Laughter.]

CHAIR THOMPSON: Okay. All right. Chris, I'm wondering, to just get us started for this part of the conversation, if you could remind the Commissioners and the public where we are with some different pieces of work that are in progress around prescription drugs so that we can also keep that in mind.

### FURTHER DISCUSSION OF STATE INNOVATIONS IN DRUG PRICING
MR. PARK: Sure. So last year we had discussed some very technical changes to the rebate program in terms of misclassification and things like that. That was recently taken up in a House bill that they voted on, so, you know, some of those recommendations have been considered by the Congress.

This year, we started down the path to try to look at how states' utilization management tools compare to other payers, so last month, we presented the first round of analysis that we've done comparing Medicaid's coverage of drugs and their use of utilization management tools to other payers and, you know, broadly speaking, for a lot of drugs Medicaid seems to cover more drugs, but they also seem to use more utilization management tools, and that might be an outcome of them having to cover pretty much all drugs. So they, you know, prior auth. or put some other restrictions on it that way.

We also in September had discussed additional changes to the rebate program such as, as Dr. Jeffrey had mentioned, on the accelerated approval drugs, you know, could there be some kind of penalty or higher rebate or some other --
CHAIR THOMPSON: Which the Commission was not enamored with.

MR. PARK: Right.

CHAIR THOMPSON: Yes.

MR. PARK: Yes. So, you know, we've had discussions around that. We had other discussions of trying to kind of incentivize more value-based payment through changes to federal policy, as well as we discussed what we've been referring to as a grace period, which would give states some opportunity, like 90 days or a 180-day period, to kind of evaluate all the criteria, the FDA approval material, any research or statements made from the professional societies, the specialists, kind of what appropriate treatment patterns might be, what should be the prescription guidelines so that they would have some time to kind of consider all that to develop their criteria of coverage before they absolutely have to cover a drug. So this would kind of formalize a grace period for that.

The Commission did show interest in that particular option. We've been talking to CBO about the score on that. You know, we can come back to you once we get that score. We also discussed removing the cap on
rebates, which right now the cap is at 100 percent of average manufacturer price, and, you know, several drugs can go over that cap, and so there's maybe an incentive, once you hit that cap, to just keep raising prices. So if we took that cap away, not only would there be some benefit to the Medicaid program in higher rebates, but it could also have benefits to other payers because it might create incentives for the manufacturer to kind of slow the growth of drug prices.

CHAIR THOMPSON: Okay. So as of now, we kind of have two things that are pending that the Commission -- in terms of potential recommendations that the Commission has generally responded favorably to the grace period and then lifting the cap, right?

MR. PARK: That's correct.

CHAIR THOMPSON: Okay. I think that that's a helpful reminder.

So I'll open it up for the Commissioners to discuss about any additional concepts or ideas that we should pursue. I'll just throw one out in that. It seems to me that we have the situation where when we started going down the road of looking at prescription drug
pricing, we said to ourselves let's start to look at this through a couple of different angles. We're not looking to necessarily, especially initially, blow up the entire Medicaid drug rebate program, and I think the more that we've had conversations around that, the more that I think that's correct, that was the correct path to take, and it may not be that we want to be in the process of redesigning the entire purchasing approach for Title XIX.

I do think that we continue to come back to this issue that there are certain classes of drugs, certain types of drugs, certain -- it may be by virtue of their expense. It might be by virtue of what they do or the population that they are addressing, that we may need to trigger out of the traditional rebate program and into something else. And I don't know if that "into something else" is a regional pull, is a different economic model, is flexibility for states, is -- you know, that still has guardrails that give us assurance that beneficiaries are going to get the therapies they need, but create a different kind of economic model that make it more possible for states to deliver that.

That is a tall order, but it seems to me that
that's where it would be most useful for us to spend our time. And you see me coming back to, you know, wanting to find a way to recognize the savings that Medicaid is delivering to the American health care system, to other payers, to the American economy in some way, given the fact that Medicaid is going to, by its nature, by the fact that less healthy people are in Medicaid, lower-income people are in Medicaid, et cetera, that Medicaid is going to bear the burden of a lot of costs for a lot of people who have big needs, and that serving those needs allows those individuals to gain employment, to be productive members of society, to contribute in all sorts of ways, to ultimately maybe even leave the program and be covered by other payers who will not face those costs as a result of Medicaid's investment. It seems to me that some kind of approach to estimating and contributing to that investment would be helpful.

So let's see. Kit wanted to say something, then Alan, then Fred.

COMMISSIONER GORTON: So I will align myself with your restatement that blowing up the rebate program doesn't seem like a good thing to do. There's just too much that's
built around it, and Dr. Gee talked about whack-a-mole and
Dr. Jeffrey had a somewhat more cynical framing that PhRMA
would win in the end, anyway. And I agree with your focus
and with Dr. Gee's emphasis that it really ought to be how
do we get -- you know, how do we get drugs to people who
will benefit from them?

I do think there's a program integrity component
of how do we not give drugs and spend limited funds for
people who will not benefit from them. And so I don't know
how to necessarily square that circle, although what I
would say is we've had a number of people, including
today's panelists, who have said, you know, we think we can
figure out a way to work around best price. And I wonder
if there shouldn't be a more formal mechanism -- I mean, I
think the rebate system works for 95 percent of the stuff,
right? It doesn't work for really expensive things. It
doesn't work -- particularly really expensive things
affecting big populations. It doesn't work for inpatient
injectibles because, you know, they're not part of the
program.

So I would be interested in figuring out whether
the Commission could come up with policy recommendations
around tweaking best price so that it stays in place for
the 95 or 98 percent of things that it's working okay for,
but so that if a state were to enter into a value-based
arrangement, that we would just say, you know, okay, that
money is excluded from best price, that's not an element of
the calculation of Medicaid best price.

So that if somebody wanted to negotiate a
supplemental rebate for a very expensive drug for very ill
children, that somehow the manufacturer could do that
without triggering that best price trigger that seems to
hold people back.

So I just wonder -- and maybe Chris has some
ideas about this -- whether there's one or two or three
little carve-out, waiver, or safe harbor kind of provisions
that we could offer with respect to best price that just
might level the playing field a little bit and keep us in a
place where drugs are affordable to the public payers and
their managed care partners.

The other thing I just wanted to sort of note
here -- and I thought Dr. Gee did a wonderful job of
pointing to the fungibility of the beneficiaries of the
program, right? So they go into the workforce, they go
into Medicare, they go into prison, they come out of prison, right? So she didn't say one of the benefits of treating people in prison is that at least in states that have done Medicaid expansions, when they come out of prison they go into Medicaid. And so in Massachusetts, we put a fair amount of energy into that particular transition because if the state started paying for a course of therapy for hepatitis C, then we don't want it to get interrupted — you don't want to keep them incarcerated just to finish their course of therapy, and you don't want to not start a course of therapy that they should have started because they might get out soon. So there's -- that whole transition is interesting and different in states that have expanded from states that have not.

But I do think that you've put your finger on something, Penny, in terms of -- and Dr. Gee I think very elegantly framed it in terms of the public health element that Medicaid plays here. And maybe the answer is not to try and avoid it or try to spread the cost out, do some complex cost allocation, but merely to acknowledge, and maybe what we should think about is having Congress acknowledge in Title XIX somewhere that Medicaid, in fact,
plays an important population health role and an important public health role, and that in some way expenditures in those ways, you know, they're matchable and people should get credit -- the state should get credit for the investments that they make in that.

So, anyway, that's a lot of maybe if, kind of, sort of, and nothing very clear, but I do think that we might be able to point out a couple of avenues of policy that would just create a little more breathing room for the states and for PhRMA and the provider community.

CHAIR THOMPSON: Thank you. Alan?

COMMISSIONER WEIL: Well, if there's one conclusion I reach from serving on the National Academy's Committee on Affordable Drugs, it's that dollar flows in the pharmaceutical sector make supplemental payments look simple, so, staff, I mean, really, I don't know why you haven't figured supplementals out yet given how much higher the bar is here.

I want to try to take these two comments and be a little more precise. I appreciate the comment of not blowing up the rebate system, but there is a lot of talk about having some significant debate at a national level...
about drug pricing in the coming Congress given comments from the President, change in leadership. I think it would be a huge mistake for us to be absent from those. Much of what Medicaid is dealing -- Medicaid cannot do alone what needs to be done. We may not all agree on what needs to be done, but we can certainly agree it can't do it alone. And so I think along the lines of things we have done on other kinds of policy initiatives, being aware of the evolving federal debate which will have potentially tremendous consequence for Medicaid as a program and Medicaid beneficiaries, we should be a part of that. And I would, of course, also being a member of the National Academy's group, would say that where there are opportunities to actually support changes that would be positive for the whole affordability and availability, where appropriate, to have a Medicaid voice supporting that I think is important. So I don't want us to shy away from the big stuff given the potential of that discussion occurring.

I think the micro changes around categorization, newly approved, you know, we should keep doing that. I don't have any question. But I guess what I would wonder -- and I think this is where I'm trying to follow on the
last two comments. The two things we heard, they're phenomenal, and they come from phenomenal leadership, as great ideas always do, and tenacity. There's actually a lot else going on out there that's -- I'd call it a notch below in terms of how transformative the state efforts are trying to be, still very important, very difficult. These are, I would consider sort of from my look at it, the highest level. And I think us trying to focus on, given that this issue is not only not going away but is certainly going to get worse with new therapeutics that are more expensive, that us trying to spend a little more time in that middle segment of what is needed for states to be able to experiment -- these are not success stories. These are interesting ideas. We need more of them. And I think we ought to really think as a Commission about -- and hear from states and hear from industry about what it takes to create more room for this kind of creativity, because we're not ready to say, you know, Louisiana figured it out, we should do it nationally. Absolutely not. And I think the mixed feelings, the reaction to the proposal in Massachusetts is also a sign of how fraught these issues are. But we've got to create the space for that or else
this is -- or the alternative universe is really grim.

CHAIR THOMPSON: Yeah, and I don't -- when I say not blow up the rebate program, meaning that what we keep hearing is that there are situations and classes and issues that the rebate -- the constraints of the program, the deal of the program doesn't serve well. And we ought to be focused on those situations, and maybe there's a different system that applies there and a different, again, trigger into a different world, whether that world is flexibility or options or something that happens outside of the state or different financing mechanisms or whatever. I think that if we look at it from the standpoint of these classes of -- as we have in the past started to peel away the layers of some of these classes of drugs, classes of therapies, what it means to the beneficiary, what costs it imposes on the system, et cetera, then that might help us understand some of those different approaches that could be used.

COMMISSIONER WEIL: I just have to say I would not agree that the rebate system works effective for the vast majority of drugs. Just put that on the record.

CHAIR THOMPSON: Well, say more about that, Alan,
meaning the --

COMMISSIONER WEIL: Oh, I don't know where to start. I mean, I would almost want to turn around the question and say, "How does it work well?" I mean, it generates -- it certainly gives Medicaid a better price than a lot of other payers, and that's a good thing. Whether it's the right amount, I don't know. We've heard presentations about the variable ability of states to generate -- what's the word? Not supplemental -- yeah, supplemental rebates based on criteria that I frankly don't think relate to value or anything like that. And it's all based off of prices that are completely -- in large respect, completely arbitrary.

So to say that it creates a dollar flow and gives states a better deal than other payers based on something that makes no sense, I agree, blowing it up isn't good because you don't want to ship all that money back. Look, I don't want to dominate the discussion here. I think we learned -- I feel that I -- this is not an area that I felt to be expert in. I feel that I learned, and read our report, it's long, good and long. You know, the ecosystem of pricing is not value -- is not related to value. That
is -- and so a rebate structure off of something that has no relationship to -- little relationship to value doesn't to me solve the problem.

CHAIR THOMPSON: Thanks for that.

I have Fred and then Darin.

COMMISSIONER CERISE: Well, gee whiz. Just to follow a little bit on that, it is -- and, again, I was in the camp of I realize we don't want to blow up the rebate program and start that over. But, you know, the system that it's based on, you know, these different piecemeal approaches, we're going to give rebates, we're going to have patient assistance programs, we have just these different approaches that you really are trying to solve a public health issue, is not -- is not the way you would design it from scratch, let's say. And so if there is a way to push more transparency, you know, the fact that you've got these negotiated deals and the Secretary can't even see the dollars, you just see a dollar sign or three dollar signs, because you're going through some other entity, it's just absurd.

And so, again, I'm not saying it shouldn't be our agenda to take on rebates, but I agree with Alan. I
wouldn't shy away from that discussion because it's just not a -- it's a complicated system for a reason, you know, because people are making money off of a complicated system, and there's a lot to be made here.

Just a couple of specific comments. I do agree that perhaps a way we could make a statement is to create some room for this to look at these a little bit differently. For instance, as I'm thinking about Rebekah's business -- if that's successful, you're going to have one vendor, right? I mean, you're going to have one drug because I don't know how you would do a subscription service that didn't say, okay, we're going to pick you and just you to do the whole population. So, you know, you're going to have to have some flexibility to work through these things that we don't have today. And then if that's successful, there really are national implications that go well beyond Louisiana. So just some thoughts around that.

On the specific, I thought Paul's points on the accelerated approval process were important points, things like, you know, the ability for states to look at that and say, you know, we're going to limit to label or we're going to limit to what the clinical trial actually says it was
effective to do is important, and I wouldn't pass on that, either.

COMMISSIONER GORDON: So I agree with Fred, your comments there. Also, to echo Alan's comment, the drug rebate system is a tool, albeit an imperfect tool. And so it could be improved upon. So I don't think we completely blow it up, but I do think we do have a conversation, are there things that could be done to improve it or to come up with a different model that, to Alan's point, drives more toward value, being based on value as opposed to a formula that can in essence be backed into in the rate development process?

Medicaid best price keeps coming up, and I do think we should consider recommending, whether it's statutory or whether it's through some other means, somewhat of a safe harbor for exceptions to Medicaid best price when it is a situation that is, you know, a value-based purchasing arrangement that is being negotiated between the state and that particular manufacturer or, you know, you can get an advanced value-based purchasing, not that it's superficial but something of substance, because whether it's a real hurdle or not, practically speaking it
is limiting some of the development of some more creative arrangements between states and manufacturers around some value-based purchasing models, and I think a narrow safe harbor or exception around that might be worth considering.

MR. PARK: Can I just make one clarification on Medicaid best price? So if the state enters into a value-based arrangement with a manufacturer and it is considered a state supplemental rebate, that is not --

COMMISSIONER GORDON: That is not --

MR. PARK: That is not considered best price, and that would --

COMMISSIONER GORDON: Correct, exactly. But my point being it's in that narrow realm of if it's involving supplemental rebates, and I think that creativity can go well beyond that, so I think -- I mean, thank you for clarifying. There is that -- and Dr. Gee even pointed to it. There's some work-arounds to Medicaid best price, supplemental rebates being one of those, but I think there's probably more potential out there beyond that if given the room to do so.

CHAIR THOMPSON: Okay. What I want to try to do is, you know, I think we have -- we owe the staff some
guidance on exactly what we want them to focus on and some of the things that we think are most apt to produce insight and recommendations that we can act on. And I think, Alan, your point that there might be some room to interject ourselves and some discussions is absolutely right, but that also puts some pressure on us around making some choices and setting some priorities and making sure that what we have to offer, you know, has the appropriate evidence and database to be compelling and useful to that conversation.

So, Chris, having heard some of what we've said, I know we were talking a little bit at the break about whether this lens of looking at certain classes and types of drugs and how well or not well the rebate program kind of serves or doesn't serve, in addition to kind of keeping some of these other mid-tier or lower-tier looks at tweaks and modifications and improvements on the rebate program going. Does that seem like something that you think provides a framework that we can use for discussion? And I think bringing in the National Academy recommendations and conversations as part of that as well, is that enough guidance for you to be able to think about some potential
ways in which you can come back with some data and
suggestions for us?

MR. PARK: We can, I can think about it. I think, you know, Dr. Gee made the analogy to the Vaccines for Children Program.

CHAIR THOMPSON: Right, exactly.

MR. PARK: So there may be some cases where there's a strong public health interest where maybe you take that class of drugs, like the hepatitis C curative treatments, and move that outside of the rebate program.

CHAIR THOMPSON: Right.

MR. PARK: You know, Dr. Jeffrey had mentioned some of the cell and gene therapies, so that might be another place where --

CHAIR THOMPSON: Where you're in an amortization kind of model --

MR. PARK: Yeah, or even, you know, like a narrow kind of definition of what is -- like maybe certain things, because particularly with how these are being paid for in the inpatient setting, you know, should these be kind of considered outside of the outpatient drug program. So I think we can certainly think about that. I think the
challenge will be kind of like if you really want to be specific in trying like how to identify, you know, does this therapy deserve special consideration or not, I think that's where we would have the challenge of trying to come up with that level of detail. But if you wanted to make more of a broad statement of here are the types of things that maybe CMS should consider and have authority to carve out of the drug rebate program, that might be where the Commission could come up with at least some kind of recommendation language that, you know, kind of doesn't put the onus on the Commission to say Classes A, B, and C should be carved out, but, you know, would give CMS or another entity the authority to kind of make that decision.

CHAIR THOMPSON: Okay. I just want to make sure that, when we go about this, we don't single-thread this onto -- it gets back to this point that we need some different levels of creativity being exercised here. And so, you know, the administration came forward with an idea about, you know, here's -- let's allow five states to go in. That was why I was asking Dr. Jeffrey about like, well, okay, is the problem there it's an all-or-nothing proposition and so you can't totally walk away from the
rebate program. And so is there some different kind of an approach where there's an ability to segment that risk in a different way to present some flexibility, again, with the idea of delivering needed therapies to beneficiaries, but produces a different relationship or a different way of purchasing or a different cost profile to the state. So I want to think about that, too, so that it isn't just, you know, the federal government -- suggesting that the federal government preplan out all of the places where there might be a different exercise of state authority or a different economic model that could be used. So just think about that, too.

MR. PARK: Sure.

CHAIR THOMPSON: Whether there's something more structural about how states decide to be a part of the rebate program or not and give some kind of middle ground so that it's not an all-or-nothing proposition.

Fred, do you want to jump in?

COMMISSIONER CERISE: Yeah, I thought Paul, some of his points, it's out there. You know, like the state's going to determine what the price -- what's a fair price. Essentially what you're doing is you've got this huge...
population you say you must cover, you must buy the drug
for, and you must pay what is being determined is -- so I
think, you know, the thought along what Paul was
describing, how do you get to something that's fair, and I
realize that's controversial, but it's also controversial
that we've got tens of thousands, hundreds of thousands of
people with hep C that just aren't getting the drug at all.
And so it's a sticky thing, but, you know, I think the
economic model and how do you work on behalf of the
Medicaid program to buttress the negotiation on that side.

CHAIR THOMPSON: Martha.

COMMISSIONER CARTER: I'm a little hesitant to
weigh in because drug pricing is not my area of expertise.
But I was particularly intrigued with Dr. Gee's
description, and perhaps it would be helpful for us to
frame a conversation around drugs that are potentially
curable - are curative. So, you know, infectious diseases
like hep C or some of the gene therapy, because there's a
different business proposition for pharmaceutical companies
when they're developing those drugs. And so there should
be -- it makes sense that there might be a different
pricing model, and maybe even a rebate model -- I just
can't go there -- for those drugs, because they're not like
a drug that's going to be -- that a person is going to take
for a long time.

And so that might be just a class -- it's messy,
but it's a class of drugs that are projected to be fairly
immediately curative, which means they have a shorter
business life, if you will. I don't know the correct
terminology. Because I think that would be an area to
innovative in and to think about pricing differently.

CHAIR THOMPSON: Okay. Great. Good
conversation. Chris, as usual, we look to you to come back
with some maybe additional structure, based on this
conversation, and some ideas about some modeling or
analytic approaches that could be useful to help us
continue these conversations. So much appreciated.

CHAIR THOMPSON: Okay. Our next session is going
to be on network adequacy in managed care.

### NETWORK ADEQUACY IN MANAGED CARE

* MS. FORBES: All right. So the plan for this
session, I'll recap why this is on the agenda again; remind
you of the federal standards for network oversight in
Medicaid managed care since we last discussed this in
September; explain the work that staff did to look into this area; and go over our initial findings.

During your discussion at the September meeting about Medicaid managed care oversight, you raised questions about the adequacy of oversight and about meaningful oversight, how the requirements and processes translate into accountability.

CMS is considering two regulatory actions that could affect managed care access oversight. The equal access rule would exempt states from fee-for-service access monitoring if they have more than 85 percent of enrollees in managed care. As you may remember, the Commission sent comments in last May. CMS is still working through its process on that rule.

The managed care notice of proposed rulemaking came out on November 14. We will talk about that later this afternoon. It also includes some proposed changes to network oversight, so this session today is timely.

Several oversight provisions of the current rules went into effect in 2018, just this last July. This includes rules requiring all states to follow the same standards and to have network standards in their quality
strategies. So this year is really our first chance to look at states and find out what they are doing.

There are federal rules which have evolved over time for how states and MCOs must ensure that people who are enrolled in Medicaid managed care have timely access to services. There are several things that states must do:

develop network adequacy standards and access requirements for a range of provider types; include a contract provision requiring MCOs to document their compliance; list the network adequacy standards and access requirements in a state formal quality strategy, and make those publicly available on a state website; monitor the availability and accessibility of services, including network adequacy standards; and impose sanctions if necessary.

CMS has also provided some regulatory guidance to assist states in implementing these rules. In April 2017, CMS published a toolkit that included a framework for developing network adequacy and access standards and suggested metrics for monitoring provider network adequacy and service availability to assist states in developing these quality strategies and update their network standards in time for these 2018 rules to go into effect.
We wanted to see how states put all the pieces on the previous slide together – standards, monitoring, and enforcement -- to implement meaningful oversight. There are 42 states with comprehensive managed care programs. We wanted to collect the most current publicly available contracts, network adequacy standards, and quality strategies from as many states as we could. We ended up attempting searches for 20 randomly chosen states and we were able to find documents from 14 of them. It would have been more but the rule came out in the middle of our work, so we ended up getting about a third.

We reviewed the documents to identify the degree to which they comply with the requirements of the current rule and implement the suggestions in the CMS toolkit. We were hoping to inform the policy questions raised in the earlier Commission discussions regarding meaningful federal and state oversight, so I'll walk through our findings in the various areas now.

The rules promote transparency by requiring states to put certain information on the state website, including the network standards, the state quality strategy, and the base or model contract with the MCOs.
The contracts were supposed to be online as of July 1, 2017, and the quality strategy and the network standards as of July 1, 2018. Most states that we looked at -- again, we found information for 14 -- have a draft or final quality strategy available online. Some states hadn't updated the online version for several years so we weren't always sure if we were looking at the most recent version. We went with what we could find online.

A lot of states incorporate the network standards into other documents that are available online, such as the quality standards or the MCO contract, so they were available. They just weren't always a standalone document. Some states provide a model contract online and some states provide copies of the actual contracts with their MCOs, which, for transparency purposes, you know, either will do. And some states include things like network standards or required reports, access monitoring procedures, and other documents like operations manuals or contractor's scope of work that they reference. They incorporate, by reference, into the documents that we are looking at. So if we looked at a contract and the contract said "we're incorporating this by reference" and they had a link, then we would look
We looked to see, first, how states defined network adequacy and access and the metrics they used to measure and monitor provider networks. The requirements can include things like time and distance standards, standards related to timely access, such as appointment wait times, things like provider-to-enrollee ratios. We also looked for standards relevant to specific populations, things like pediatrics or obstetrics, and for comparison benchmarks from fee-for-service or commercial insurance, some of those measures of realized access.

All 14 states we looked at had multiple standards beyond time and distance, which are required. States that covered managed long-term services and supports had separate standards for those providers. In a lot of cases, some of the standards only applied to certain provider types, such as a lot of states had member-to-provider ratios for primary care but they didn't have that for every single other provider type.

Very few states described metrics that could be used to measure realized access or network adequacy beyond time and distance. You know, all of the states said you
have to maintain a network of providers to meet geographic access standards, but we only found a few that had a metric beyond that, to see what beyond that would be considered acceptable. Florida requires, for example, that a specific percentage of PCPs accept new Medicaid enrollees.

Many states described access goals and access monitoring in their quality strategies, but the goals were described in terms of visits or clinical outcomes, not network access measures. For example, Delaware -- this is just an example -- has a statewide goal to improve timely access to appropriate care in services for adults and children, but the measures are HEDIS measures for adult access to primary and preventive care services. They said they look at quality of care and complaint data. They would look at critical incident reports to monitor progress. They didn't really talk about network access and adequacy. They talked about more outcomes measures in terms of how they would look at that.

We also looked to see how individual states specified the network adequacy standards and reporting requirements in the actual contracts. States have a lot of flexibility in determining the format and timing of the
network documentation that they require. The only federal
requirement is that it has to be at least annual or
whenever there is a significant change.

Most of the contracts we looked at had a number
of provider and access-related reports that MCOs had to
submit, in addition to that detailed provider file. For
example, Arizona requires MCOs to report unexpected changes
in provider networks. Georgia requires reports indicating
the percentage of members without access to a provider
within the time-and-distance standards. Kansas requires
MCOs to report on visits to non-participating providers.
We saw a lot of different examples.

Many contracts we reviewed also require other
information that could be used for access and network
adequacy monitoring, such as member grievances, provider
grievances, surveys, encounter data. Also, many states now
require MCOs to develop something like a comprehensive
network development plan, which is similar to a
comprehensive quality improvement plan. That's an option.
It's not a federal requirement but many states are now
requiring sort of a comprehensive approach to how a plan is
thinking about network access and adequacy.
We looked at the documents to try and determine how states are monitoring network access and the managed care program as a whole. States can use a variety of mechanisms to monitor networks and overall program access. They can look at the reports and analyses that the MCOs are doing, or they can develop their own analyses using program data. They can contract with their external quality review organizations to conduct analyses on their behalf. All of the states are getting, obviously, their periodic MCO provider network files and the reports from the MCOs.

Most states appear to be using multiple methods to monitor access, including compliance with the time-and-distance standards as well as other measures of access and availability. All 14 states we reviewed either required the MCOs to conduct a member survey or the state to conduct a member survey, or both. Half the states also conduct or require their MCOs to conduct a provider survey. Nine of the states explicitly said that they were using the provider file or they were requiring the MCOs to do geomapping analysis, to demonstrate compliance with the time and distance. Again, that was the ones where they said that they were doing that. There may be more that are
doing that as well.

Seven states require secret shopper calls or other mechanisms to monitor compliance with appointment scheduling and wait time standards, and about half the states are using their EQRO to assist with access monitoring. For example, Illinois uses its EQRO to validate time-and-distance compliance, and Indiana actually used its EQRO for one of its performance improvement projects was looking at geographic access to dental and vision services.

And finally, we reviewed MCO contracts to determine whether there were penalties associated with network and access deficiencies or network and access specific reporting failures. States are allowed to impose financial and non-financial penalties on MCOs for failure to comply with any provision in federal statute or regulation. Most of the contracts we reviewed listed only the sanctions that are explicitly listed in the federal rule. While this rule allows states to impose sanctions if an MCO misrepresents or falsifies information, which would include network information, we didn't count this. It's not sort of explicitly a network adequacy enforcement
About one-third of the contracts we reviewed included financial penalties specific to network access deficiencies or network reporting failures. For example, Florida's contract allows it to penalize MCOs $5,000 for failure to report significant number of changes in a timely way, and $500 per day for failure to provide services within the geographic standards. And we were able to find reports from Florida that they are actually routinely collecting fines from MCOs. Georgia, similar to Florida, has different penalties for access violations and for reporting violations. Georgia's contract allows it to penalize MCOs $100,000 per violation for failure to provide an adequate network to provide sufficient access by provider type, and $5,000 per day for failure to submit attestations or reports.

So our goal was to provide you with more information on how states conduct meaningful oversight of network adequacy and access, and to try and do that by reviewing the publicly available information from state Medicaid managed care programs in order to bring this back to you this fall. We reviewed state documents to learn how
they’re implementing federal requirements to ensure that enrollees in Medicaid managed care have timely access to services, and we hope to inform some of the policy questions that have been raised in earlier Commission discussions regarding meaningful oversight.

We learned that despite federal rules requiring states to make certain information available online, it would be difficult for a member of the public, including managed care enrollees and providers, to locate a lot of these documents. All of the documents we reviewed yielded information on what is monitored. We weren’t able to learn a lot from just looking at them, just from the document review, about how states use the information they collect to identify potential problems. In particular, the lack of performance metrics makes it difficult to understand what level of deficiency triggers corrective action or contract sanctions. Of course, again, it was reviewed -- our review was limited to publicly available documents and we could learn more about meaningful oversight if there is further work you would like us to do.

So with that I am happy to answer any more questions about our findings or our approach, or if there
are additional things you'd like us to follow up on we're happy to do that.

VICE CHAIR LAMPKIN: Thanks, Moira. That's really helpful baseline information.

I have a couple of questions and maybe some things I'd like to see a little bit more. But the questions, where you able to determine -- and I understand it was a limited review of publicly available information -- were you able to determine, from what you looked at, able to provide any insights as to how the states are thinking about a couple of things in the context of network adequacy. One is essential providers and safety net providers. Are they being factored into network adequacy requirements, and if so, how? And the second,

MS. FORBES: So we didn't -- so our approach was we looked at the guidance that CMS put out and sort of the high-level indicators in different categories of access that it had noted, and looked for those in the various documents. And essential providers and safety net providers and telemedicine were not high enough level things for us to have specifically sort of checked those
off as we went through the documents. I did see that many states, you know, had either listed those as things that they collected information on, had provider standards for, or had an exception policy for, but I didn't sort of systematically collect that information as I went through them. So I can say that states are doing that but I cannot quantify that for you.

VICE CHAIR LAMPKIN: That's helpful. I mean, it was clear that your focus was on looking at the federal regulations and seeing that transference. And so I just didn't know whether you'd come across that.

I think, for me, those areas are ones that seem helpful to understand to what extent states are using those and bringing them into network adequacy, and how they're thinking about them in that context.

The other thing -- I don't know that we've talked about it much in the Commission, but related -- another thing that happened in the 2016 managed care regulation is that CMS now requires actuaries in the context of rate setting to consider network adequacy challenges and gaps as they think about capitation rate development. And so that has, as you can imagine, a lot of us really trying to think
about, well how do you do that and what does that mean, because there are all kinds of reasons things that could cause gaps in network adequacy that don't translate into a capitation rate adjustment, for example.

And so one of the things that I'm curious about, coming out of that train of thinking and conversation that's happening within my profession, is what are states finding in terms of where there are gaps in the standards, how are states managing that? So this comprehensive network development plan that the MCOs have to provide in the states that have that, does that address how you resolve gaps, and what kinds of gaps are responsibilities for MCOs to resolve, and do they have the tools to resolve versus the state versus the market? You know, how are states wrestling with that question of how to resolve the gaps and whose responsibility it is?

MS. FORBES: So that's a good question. So what is required in a network development plan would be outlined, generally, in an RFP, which is not a document that we looked at. I have helped MCOs respond to RFPs and I have written these documents. And so the kinds of things you're talking about could be addressed in a network
oversight plan, and we could go find -- I know some of the states that require those, and so that's something that we could pull some information on. And that is exactly the sort of thing that an MCO would be, you know, how are they -- where they're identifying gaps. Are they looking at alternative payment strategies? Are they looking at workforce development? Are they looking at providing staff extenders through MCO staff? What are the different mechanisms that they're using to help, you know, support access? So those are the kinds of things that the MCO might do. So we could certainly collect more information on that.

In terms of the linkage to the cap rate guidance, we didn’t look at that. We didn't see a lot of information on how there's a connection between what is being required on the network side and what is required on the payment side. We didn't see, I think, anything on the federal cap rate review side about how that piece is being enforced.

VICE CHAIR LAMPKIN: Right, and that actually wasn't part of my question. That was just the lead-in to why I've been having a lot of conversation about network adequacy gaps, you know, among my colleagues and clients,
and what does that mean. And so I think that that is a useful -- not just because of the actuarial challenge, but to me it seems like a useful avenue to pursue that's really outcome oriented and meaningful, is how are states and MCOs approaching different network adequacy gaps that are caused by different kinds of challenges. Are the states just going, "Oh, you're right? There is no pediatric cardiology" -- I don't know, a great specialty -- "in that particular part of the state. I'll give you a waiver of your network's adequacy requirement because there aren't any," or how are they approaching these kinds of issues?

It's just, I think, an area that would be fruitful for us to look at further.

Darin?

COMMISSIONER GORDON: Yeah. I think what's hard is, getting to your question, it's not laid out in the contract. It's more or less the process of the state administrator. So in our case, you know, there would be a request for a corrective action. The corrective action plan is does it seem reasonable to solve the problem and then follow up, did they actually implement it, and validate that it's working. And you don't have that in a
contract. It's more of an administrative process, which is hard for you all to get at without a more extensive review.

I think the other component of that -- and this is something I saw over 20-some-odd years, where we didn't get some things right -- we had, in our contracts, in some cases, network standards that were arbitrary and capricious. We just made them up, apparently, because, you know, the expectation, in some cases, was that the health plans would build a hospital where a hospital didn't exist. And for many years, in the early part of the program, those plans were assessed damages for not having a hospital in those communities. And again, we had to re-evaluate.

So one of the things that, when we looked at that and said, that's setting people up to fail, we ended up including language in our contracts around community standard, to recognize, in some cases, that in those communities that provider is just not available, and the demographics couldn't support it, but what's your plan, still, to how you get folks access to those services. So that's where it gets complicated, because particularly in - - I mean, every state's got its own unique geography, and where the providers are and how things shift, and how you
account for that. In our case, what we had done is we had just developed some stuff not knowing, and it stayed there forever until we re-looked at it and tried to make sure it made sense with what the market looked like today.

VICE CHAIR LAMPKIN: And I definitely didn't expect that the review that has already been conducted would be turning up stuff like that, but as we just think about what further avenues do we think are fruitful for us to explore, understanding how states know, is this a reimbursement issue, or is it something else? And does it tie back to do we want to think about graduate medical education and the way we structured that program in the state related to this or not? Those kinds of things would be interesting but probably case study or limited state investigation-type studies.

Brian and then Sheldon.

COMMISSIONER BURWELL: I think we are going to build on the same theme of how states use network adequacy standards to provide access to services that are currently not as available to Medicaid members as we would like them to be. So I'm interested in a more dynamic approach about how this policy tool is used by states to increase access
to certain services.

I know, I mean, in the area I know, like in MLTSS, which is not an entitlement, by the way, so I think that kind of confounds through the requirements, how to increase access to personal care attendants in rural areas, how to increase access for certain populations where there's very limited number of providers for persons with autism. But states are trying to use this as a tool to expand the provider capacity to meet this, so kind of that overall approach to our work I think would give it a more dynamic sense of how states are using managed care organizations and network requirements to improve access to services that have limited availability in the state.

VICE CHAIR LAMPKIN: Okay. Sheldon.

COMMISSIONER RETCHIN: First, I really appreciate the effort. I really enjoyed reading your findings, Moira. I always like it when we pick up the phone and call the states and figure out what's going on at ground zero.

I always have a problem, however, with the time and distance standards as really the indication for network adequacy, and maybe it's just me.
I live 12 minutes from Ohio Stadium. I'm a faculty member at Ohio State, but I can't get a ticket for the Michigan game. I might be in the network, but I don't really get access to the goods.

And I was really interested, Moira, when you looked at the sample of states that you called. Maybe you already mentioned this and I was out of the room, but did you see any difference in the ability of states that have expanded Medicaid? Maybe this is a territory I am not supposed to go into, but I will, anyway.

In particular, the certain specialties that may be relatively rare, I would have thought would have difficulty in assembling a network like oncology. That they would have a difficult time. Did you hear that?

Because it's a different population.

MS. FORBES: We looked at what they're requiring, not so much what they're achieving.

COMMISSIONER RETCHIN: Oh, okay.

I do think that coming back to this and looking at the ability for monitoring and evaluation of being able to roll out these networks is really important.

VICE CHAIR LAMPKIN: Darin.
COMMISSIONER GORDON: And just, Sheldon, to your point that you just brought up -- and I think you touched on it a little bit about what others -- what states are doing like through their EQROs to do some additional validation, that while folks are meeting those standards -- because I think the standards in and of themselves, like you said, are insufficient. There's all these additional things that have to be done, and I think you identified some of the things that states are doing in that regard.

The area -- and this is what I've always thought because time and distance is one thing. Validating really what's going on at those practices is another. Monitoring your call lines, even, to identify, while it may look like there's a dot on the map, if there's some access issues that are occurring, what you're doing with that information.

But, also, this is why it's such a complicated factor, so I applaud you for all what you were able to get online because some of this stuff just doesn't come to the level of them posting it online, but even looking at the fact that you have some providers getting to your specialty and subspecialty situations, some markets where there's a
single provider and not just on Medicaid -- you see it on the commercial side as well -- that won't go in network but will see your members and validating that that in fact is happening through claims data, because they want to control their panel size and the distribution amongst the different payers, so it gets really complicated really quick.

So I think those time and distance standards is a base-level test, and then there's all these other things that you described and even more that need to be done to have a more accurate picture of really what's happening.

VICE CHAIR LAMPKIN: Kathy and then Bill.

COMMISSIONER WENO: Yeah. Just to follow up on a lot of what we're talking about, dental networks are a big problem, and when I worked in Kansas, in the western two-thirds of Kansas, there was only one pediatric dentist. You're talking about at least over 2- to 300 miles, even to find someone that would qualify for that. So, although time and distance standards are important, in some cases they're relatively meaningless.

Then the other thing among dental that was particularly challenging is accountability. Most MCOs would use a dental administrator to do their networks and
create another level of accountability and difficulty in trying to pin an MCO to a network standard, who was collecting that data and who would you call. You could really get quite the runaround, so it was an interesting place to work.

COMMISSIONER SCANLON: I know in other contexts that the receipt of a service is considered a process measure and not an outcome measure, but I think here, receipt of the service is really an important outcome. The standards, payment rates, and anything else that plays into that actual access, I think is key.

For me, the time and distance in part is part of the message that you cannot be satisfied by too high of a level of examination in terms of geography. If across a broad area, we've got access meets some standard of 70, 80 percent, that may not be very reassuring because we may have pocket areas where people are not getting access, and I think that needs to be looked at.

It's very analogous to what we were talking about in earlier discussions about oversight with respect to fee-for-service. If only 10 percent of the population is still in fee-for-service, is that reason to not monitor what's
happening to them? Because they may be 10 percent of the
people for whom access is a critical issue, and I think the
same thing needs to apply here. We need to look to an
outcome which, in this case, is actual access, and
secondly, we need to disaggregate it enough that we can
really feel reassured that the access is sufficient for the
subpopulations that are involved.

VICE CHAIR LAMPKIN: Anybody else?

[No response.]

VICE CHAIR LAMPKIN: What I think I was hearing
going around is some interest in learning more about other
metrics, other than time and distance, what states are
using them and how they are using them; maybe a little bit
more on certain providers and provider types and the
structure around that, essential providers. Modalities
like telemedicine, I think that would be interesting; then
maybe down the road, network adequacy gaps and solutions
for them.

I think I was the only one really making that.

CHAIR THOMPSON: I'll chime in to say I agree
with that.

COMMISSIONER GORDON: Yeah, I agree too. I'd say
it's how states are -- how they react to those gaps.

VICE CHAIR LAMPKIN: That's right. Yeah.

Martha.

COMMISSIONER CARTER: Moira, do any of the states use surveys of their PCPs to analyze their specialty gaps? Have they sent surveys to beneficiaries, which is sort of a proxy for access?

I know if I went and talked to our primary care providers, they would be able to tell you in a heartbeat where they can't get their patients in for specialty care. Does anybody do that?

MS. FORBES: So this is the limitation is that I know that they do a provider survey.

I know in the beneficiary survey, they use CAHPS, and I can look at the CAHPS questions. I don't know what states are using for provider surveys or what questions the MCOs are asking, but that's the sort of thing if there's interest, we could try and get more information on what --

COMMISSIONER CARTER: I know I've never seen one, a survey like that.

MS. FORBES: Yeah.

COMMISSIONER CARTER: It would be really
interesting.

MS. FORBES: We could try and find out.

CHAIR THOMPSON: I think that's a good idea.

I do think this issue of when we know our measurement systems aren't perfect or even necessarily optimal -- and I think that's what I take away from this is that we don't exactly have a set of industry standards that we have high confidence in that we're collecting data in a way that allows us to know if we really have the proper access or not.

When that happens, it seems to me that like having sentinels in the field providing real-life, real-time feedback becomes a really important compensating structure that you can use.

So I think we ought to recognize that we're never going to get to -- I won't say never. It's hard to get to a place where everybody agrees on a set of standards and says, "If I have data around all of this" -- and to Bill's point, even when you have that, the question of whether you have the level of detail you need, right? So things may look good form this level but not maybe so good here and maybe terrible right here, and how do you know that that's
happening?

So I think this question of how do you make use of the human intelligence in the field and the family members, the providers, and others who can provide insight into, in reality, "I cannot get an appointment, and I cannot get care that I need," how does that information structure play into this, I think that's a useful thing to think about.

VICE CHAIR LAMPKIN: All right. If that's it on network adequacy, we adjourn for lunch.

CHAIR THOMPSON: Okay. We will be back at -- I think the schedule is calling for us to be back at one o'clock. Okay. We will be back at one o'clock. Thanks, everyone.

* [Whereupon, at 12:05 p.m., the meeting was recessed, to reconvene at 1:00 p.m. this same day.]
CHAIR THOMPSON: All right. We'll give the one-minute warning, please.

[Pause.]

CHAIR THOMPSON: All right. The first part of our afternoon is fun with Rob, and we're going to have a session on DSH and a session on UPL. And we'll just flow from one to the other and see where we end up.

So, Rob, do you want to kick us off?

### DISPROPORTIONATE SHARE HOSPITAL ALLOTMENT

#### REDUCTIONS: PROPOSED RECOMMENDATIONS

* MR. NELB: Great. Thanks, Penny.

So, yes, we have a double dose of hospital payment today. I'm going to start by walking through some proposed recommendations related disproportionate share hospital allotment reductions.

So I'll begin with some brief background on DSH allotments, which you all know well by now, and then I'll focus most of my time walking through a proposed package of three recommendations.

I'll be looking for your feedback today on the
recommendation language itself as well as on the rationale that will accompany the recommendations. As part of that rationale, we're also proposing to include some design considerations for Congress to consider if they did choose to implement the policy, and then we're also required to comment on the expected impact of the proposal on the federal government, states, providers, and enrollees.

At our last meeting, you asked for some more information about the state-by-state impact, so I'll be providing some more information about that today, specifically with a focus on the states that are most likely to be affected by the proposed policy.

And, finally, I'll wrap up by talking about some other DSH policy options that you might want to consider in the future. These are some ideas that you've raised in previous meetings, but that don't appear to be quite ready for a recommendation at this time. But we can keep an eye on it for the future.

So, first, some background. DSH payments, as you know, are limited by federal allotments, and these allotments vary widely by state, based on DSH spending in 1992 when the limits were first established.
The ACA included reductions to DSH allotments under the assumption that the increased coverage would reduce hospital uncompensated care costs and, thus, lessen the need for DSH payments.

These DSH cuts were initially scheduled to take effect in 2014, but they've been delayed several times. Under current law, reductions are scheduled to begin in fiscal year 2020 at a $4 billion cut, and then reductions increase to $8 billion per year in fiscal years 2021 through 2025. This is an amount that's a little more than half of states' unreduced allotment amounts.

Under current law, there is no reduction scheduled in fiscal year 2026 and subsequent years, and so in those years, the allotments will return to their higher unreduced amounts.

The statue currently requires CMS to develop a methodology to distribute reductions based on several factors listed in the statute. Specifically, CMS is required to apply larger reductions to states with low uninsured rates and is also required to apply larger reductions to states that do not target their DSH payments to hospitals with a high volumes of Medicaid patients or
high levels of uncompensated care.

MACPAC commented on CMS's proposed methodology in August 2017 and offered a number of technical comments about ways to improve the calculation of the various factors in the methodology. However, the Commission also reiterated its longstanding concern that DSH allotments have little meaningful relationship to measures of need and noted that the methodology, as proposed, does little to kind of correct some of that historical variation.

And so now as we're looking at potential recommendations to Congress, Commissioners have expressed interest in developing a new methodology rather than making further tweaks to the existing methodology.

So now let's take a look at the proposed recommendation package.

Based on feedback from our last meeting, we developed a package of three recommendations for you to consider. These include, first, phasing in reductions more gradually over a longer period of time; second, applying reductions to unspent funding first; and third, distributing reductions in a way that gradually improves the relationship between DSH allotments and the number of
non-elderly, low-income individuals in a state.

Although these recommendations are presented individually, we anticipate that the Commission would vote on them together as one package.

So let's dive into the specifics. The proposed text of the first recommendation is as follows: "In order to phase in DSH allotment reductions more gradually without increasing federal spending, Congress should revise Section 1923 of the Social Security Act to change the schedule of DSH allotment reductions to $2 billion in fiscal year 2020, $4 billion in fiscal year 2021, $6 billion in fiscal year 2022, and $8 billion a year in fiscal years 2023 through 2029."

By phasing in reductions more slowly, this recommendation aims to mitigate a potential disruption for hospitals and also provide states with more time to adjust other Medicaid payments to hospitals, if they so choose.

The specific amounts that are included in the recommendation are intended to match the level of spending that's assumed under current law, according to the assumptions used by the Congressional Budget Office.

However, it's important to note that since we're
not proposing specific legislative language, CBO isn't able
to give us a specific point estimate for the
recommendation, and so at a later time, if Congress does
choose to implement this recommendation, it would get the
specific costs or savings associated with it and could make
other adjustments, as needed, to achieve our goal of
minimizing changes in federal spending.

The second recommendation reads as follows: "In
order to minimize the effects of DSH allotment reductions
on hospitals that currently receive DSH payments, Congress
should revise Section 1923 of the Social Security Act to
require the U.S. Department of Health and Human Services to
apply reductions to states with DSH allotments that are
projected to be unspent before applying reductions to other
states."

The intent of applying reductions to unspent
funds first is to minimize the amount of reductions on DSH
funds that are currently being spent and are currently paid
to providers. In fiscal year 2016, about $1.2 billion in
federal DSH allotments were unspent, and so this amount
could offset most of the amount of reductions in the first
year under our current proposal.
Moreover, the amount of unspent funds by state has been relatively consistent year to year, and so it's likely that funds that have been unspent in the past will continue to be unspent in the future.

The memo that you have describes a number of different, more specific design considerations that Congress may want to consider if it did choose to implement this policy.

First, we talk about the method that we used in our analysis to project unspent funding. Specifically, we averaged unspent funds for the past three years in order to help smooth any year-to-year variation.

Second, we note that even though in our analysis, we weren't able to take into account funds that may be unspent in the future after reductions take effect, it is plausible that Congress could develop some method where those funds that continue to be unspent are reallocated to other states, similar to the process that's currently used for unspent CHIP allotments.

Finally, I just want to point out that we highlighted a small technical change in the statute that could help clarify that reductions to unspent DSH funds
don't affect DSH funds that are currently spent on

providers.

All right. Last but not least is Recommendation

3, which focuses really on this new methodology that we're

proposing. The language reads as follows: "In order to

reduce the wide variation in state DSH allotments based on

historic DSH spending, Congress should revise Section 1923

of the Social Security Act to require HHS to develop a

methodology to distribute reductions in a way that

gradually improves the relationship between DSH allotments

and the number of non-elderly, low-income individuals in a

state, after adjusting for differences in costs in

different geographic areas." A bit of a mouthful.

So the purpose of this recommendation is really

to begin that process of aligning allotments with a more

objective measure of need. As you'll recall at our last

meeting, we talked about a number of different potential

measures that could be used, and at the time, most

Commissioners felt that the number of low-income

individuals in the state was a good measure because it

related to hospital uncompensated care costs and also it

was relatively independent of state coverage choices.
As you will recall, we did consider basing 
allotments based on uncompensated care reported on Medicare 
cost reports or on DSH audits, but there were some concerns 
about the reliability and completeness of those data. And 
then we also looked at potentially basing allotments on the 
number of uninsured individuals or the number of Medicaid 
enrollees in the state, but we found that those measures 
were highly affected by state coverage choices. 

Commissioners also expressed support for making 
adjustments to account for variations in costs in different 
geographic areas. In our analyses, we used the Medicare 
Wage Index to make that adjustment. 

Finally, I want to point out that we're proposing 
to phase in changes gradually in order to provide states 
and hospitals more time to respond before the full amount 
of reductions takes effect. 

So our recommendation doesn't propose a specific 
methodology that CMS should apply, but as part of the 
design considerations that we're putting forth, we kind of 
walk through some of the assumptions that we made when 
we're trying to estimate how this proposal may work in 
practice.
So your memo goes into the full set of assumptions that we made, but I just want to highlight two here. First, because we're trying to implement the rebasing along with allotment reductions, we assume that the reductions to states with very large allotments would be larger than any increases to states with allotments that are below the rebased amount, so in order to achieve that full amount of cuts in those first four years.

Second, to deal with some of these outlier cases where the state's DSH allotment is so much larger than the national average, we assumed that there would be a maximum reduction amount, and for our purposes, we assumed 30 percent a year.

These are just assumptions, however, and I think we anticipate that Congress would direct CMS to define many of the specific details of the methodology, similar to what it does under current law, and this would likely happen through the rulemaking process, which would provide opportunities for stakeholders to comment and for CMS to respond to those comments.

However, it's important to note that the timing for rulemaking is quite short, since under current law,
reductions begin in fiscal year 2020, which actually begins in October of next year.

So looking at the expected impact of all of our recommendations together, CBO estimates that the proposal will result in some modest federal budget savings over the 2019-through-2029 budget period. CBO is not able to estimate the effects of each component of the recommendation separately.

The effects on states will vary, and I'll get to that in just a bit. But, in general, compared to current law, this proposal would result in larger reductions for states' unspent DSH funds, and it would also result in larger reductions for states that have particularly high DSH allotments per low-income individual.

The effects on providers and enrollees will also vary by state, and it will also depend on how states respond to reductions. As I'll discuss, it is possible that some states may attempt to offset the effects of reductions by increasing other types of Medicaid payments to providers, but it's hard to predict exactly how that will work.

So now let's take a closer look at some --
EXECUTIVE DIRECTOR SCHWARTZ: Rob?

MR. NELB: Oh.

EXECUTIVE DIRECTOR SCHWARTZ: Can I just interrupt here?

MR. NELB: Yeah.

EXECUTIVE DIRECTOR SCHWARTZ: I want to just clarify. CBO did say that it had a modest budget saving. Our goal going in was to have it be budget neutral, but it was hard to configure it to be exactly neutral. And in any case, those parameters would change so much in legislative language. So I just want to clarify that it's not intended to take more savings out, and that is something that we could also comment on in the writing of the chapter and in the rationale for the recommendations to clarify that our intent was to just deal with the amount of savings that had been currently projected.

Then Congress could figure out, for example if it was a little bit of a saver, what they wanted to do with that, if they want to put it back into this or if they wanted to adjust some parameter.

CHAIR THOMPSON: Thank you. That's an important clarification.
MR. NELB: Yeah, definitely. Great.

Okay. So now let's take a closer look at the state-by-state effects. So this figure shows the projected reduction in state DSH spending as a share of total Medicaid hospital spending by state under the proposed policy, when the full amount of reductions takes effect in 2023.

So recall that in 2023, allotments are scheduled to be reduced by $8 billion, which is about half of states' unreduced allotment amounts, and the amount is about 5 percent of total Medicaid hospital spending.

As you can see, most states are projected to have reductions that are less than 5 percent of their total Medicaid hospital spending, including all of states that have DSH allotments per low-income individual that are more than 50 percent below average.

However, there are some states that are expected to have larger reductions, including some of those states that have allotments per low-income individual that are more than 50 percent above average.

So now this slide focuses on the seven states that are projected to have DSH payment reductions that are
greater than or equal to 10 percent of their Medicaid hospital spending in 2023.

As you can see, this list includes a mix of expansion and non-expansion states that have a variety of different characteristics. However, the common theme for all of them is that they currently have very large DSH allotments per low-income individual, and so under this rebasing policy, they are expected to receive large reductions. In fact, all of these states receive reductions up to that maximum that we assumed in our policy, the 30 percent a year.

So the first two columns here compare reductions under current law to the proposed policy, and I just wanted to highlight the example of Alabama where the reductions under the proposed policy are actually less than under current law. This sort of comes back to the fact that under either scenario, we are still dealing with the same amount of cuts, the $8 billion amount, and as we think about this methodology, it's important to remember that any policy that reduces cuts for some states will result in larger cuts for other states, and so there's a tradeoff there.
The third column has information about Medicaid shortfall reported on DSH audits in 2014. In some ways, this represents the amount that states could potentially offset by increasing other types of Medicaid payments to hospitals.

So here, I highlight the example of New York, which is projected to receive a pretty large cut, $3 billion in state and federal funds; however, New York reported more than $4 billion in Medicaid shortfall for DSH hospitals in 2014.

And the final column includes information about the share of DSH payments to deemed DSH hospitals in 2014. As you will recall, deemed DSH hospitals are statutorily required to receive DSH payments because they serve a high share of Medicaid and low-income patients, and in our prior analyses, we found that these hospitals tend to have higher levels of uncompensated care and more financial challenges compared to other hospitals.

So another way that states may respond to cuts, especially in the case of Missouri where they don't have any Medicaid shortfall that they reported, another way to potentially respond is to better target the remaining funds.
to hospitals that need it most. So Missouri is a case
where they distribute their DSH funds pretty broadly, and
if they choose in the future could potentially target a
larger share of those payments to deemed DSH hospitals or
whatever subset of hospitals they think are most in need.
So this slide further explores some of the
different non-DSH payment methods that states may be able
to use to offset the effects of DSH reductions, if they
choose.

First, in both fee-for-service and managed care,
states could increase base payment rates to providers,
which are tied to Medicaid utilization.
Second, in fee-for-service, states can make upper
payment limit supplemental payments, known as UPL payments.
These are lump-sum payments, and states have pretty broad
flexibility about how they target them.
And then, third, in managed care, states can now
make directed payments to providers, which operate pretty
similar to UPL payments in terms of being an extra payment
that goes to providers, but there are a couple more
parameters around how those funds are distributed.
As you recall, last summer we spoke with
Louisiana as part of our hospital payment interview project, and we learned more about their plans to shift about $379 million in DSH payments to base rate increases to providers. The state was doing this not only to get ready for DSH allotment reductions but also as part of their larger policy goal of reducing reliance on supplemental payments. And, you know, as part of this change, the state isn't adding any more state general funds but it's just shifting the funds that were currently available from one payment method to another.

We spoke to Louisiana and they mentioned that it took them about three years to implement this policy change, which included time, not only for all the system upgrades and sort of developing the new method, but also a lot of consultation with stakeholders. Even though the total amount of funds under the new policy were the same as before, some hospitals that we spoke with were, you know, concerned that the distribution of payments may shift under the new methodology and they wanted to be prepared for that.

The last point I want to make about other non-DSH payment methods is that although states have a number of
ways that they can pay for Medicaid shortfall, it's more
difficult for states to replace DSH payments that are
paying for care for the uninsured. In addition, it's also
harder for states to replace DSH payments that are going to
institutions for mental diseases, or IMDs, since IMDs are
not otherwise eligible for Medicaid payments for services
provided to enrollees between age 21 and 64. There are
some new waiver opportunities now but that general payment
limitation still exists. And it's important to note that
in 2014, about 14 percent of DSH payments were made to
IMDs.

All right. Last but not least, I just want to
walk through two other DSH policy options for future
consideration. First, recall that at the September meeting
we talked about a recent court ruling that changed the DSH
definition of Medicaid shortfall, saying that payments from
third-party payers, such as Medicare or commercial
insurance, can no longer be counted. And as a result of
this, we expect that Medicaid shortfall reported on future
dSH audits will more than double in the aggregate. So, for
example, with dual eligibles, Medicare paid about $25
billion for those hospital services provided by duals.
Under the new policy those payments no longer count but the costs of care for those patients is still counted as Medicaid shortfall, and so it sort of distorts the amount of Medicaid shortfall reported.

The result is that it will end up increasing the amount of DSH payments that an individual hospital is eligible to receive, but also, in some states it could result in a redistribution of funding, particularly in states that distribute DSH funds based on the amount of uncompensated care reported on DSH audits. So one possibility is that it would result in fewer funds for hospitals that serve a high share of uninsured patients and more funds for hospitals that serve more patients with third-party coverage, such as children's hospitals.

So, let's see. Although states are now making DSH payments under the new policy, it's a bit difficult for the Commission to make a recommendation on this topic at this time because the litigation surrounding this issue is still ongoing. Specifically, the outcome of the litigation will determine whether or not MACPAC would need to make a recommendation to Congress or a recommendation to CMS in order to change this policy.
I also want to point out that there are some other pending lawsuits related to this issue, specifically about when the timing of this change should take effect, which just sort of further complicates our ability to weigh in on this issue at this time.

Nevertheless, even though we're not making a recommendation on this issue, we could still highlight it and comment about it in our report.

All right. Another policy that Commissioners have discussed a lot is the idea of using DSH funding to help support delivery system transformation. Specifically, we've been monitoring California's global payment program, which is a Section 1115 waiver that's testing the policy of distributing DSH funds as a global payment, tied to quality goals. The interim evaluation results of this demo came out earlier this year and they showed some promising signs of expanded access to care and better financial stability for the hospitals that were participating. The final evaluation results are expected next summer and that will give us some more information about how utilization has changed under the policy.

To help other states adopt similar models, CMS
could provide enhanced technical assistance to states to do a similar demo, similar to what they've been doing for other types of demos. However, at the September public meeting some Commissioners were a bit skeptical about whether other states would be interested in pursuing this path, especially at this time when DSH funding is being cut.

So that concludes my presentation for today. I look forward to your feedback on the proposed recommendations so that we can prepare them for a vote at the January meeting. The recommendations will be accompanied by a draft chapter that further walks through the Commission's analyses and alternatives considered, and I plan to have a draft of that chapter for you in January as well.

Thanks, and I look forward to your feedback.

CHAIR THOMPSON: Thank you, Rob. First of all, great job, as always, in capturing some of the direction from our prior conversations. And I think this lays out very clearly and very well a lot of the things that we've been discussing, in terms of both the recommendations and the impacts on how that plays out for different states and,
potentially, hospitals.

I just want to ask, I think, a technical question about one of your last points, about the third-party payments. And I know it's always tricky when there's active litigation, but is the question there what the -- I mean, is there a clear understanding that it's about the language and whether the language creates an unintended effect, or is there an actual policy question that people are debating there?

MR. NELB: So the subject of the litigation is about whether the statutory definition of Medicaid shortfall allows CMS to consider payments from third-party payers, and that's sort of been the focus of this March ruling, which had the nationwide impact sort of going forward.

There is a separate case which is about, again, the timing. And so CMS first applied this policy through an FAQ and then they subsequently issued rulemaking. And so there are questions about if it's ruled that you should count these third-party payments whether CMS can enforce that policy sort of retrospectively, or whether it's just something on an ongoing basis.
But at least the subject of the court rulings are more around the legal authority. I think you'll talk to different stakeholders and will have different views on whether, you know, this policy makes sense or not. I mean, some of the children's hospitals are particularly concerned about the inclusion of the commercial payer payments, which end up -- if those commercial payments are above costs, what it ends up doing is reducing the amount of payments that those hospitals can receive for the true Medicaid shortfall that they are having for Medicaid-only recipients.

CHAIR THOMPSON: So they see it as a cost shifting issue.

MR. NELB: Yes. Yeah. So there are definitely hospitals that are concerned about this issue, but the merits of it, the legal case, are focused on sort of who -- whether CMS or states that can --

CHAIR THOMPSON: Okay. Thank you for that clarification.

All right. So we're going to have a little bit of a Commissioner conversation. We'll have public comment, and then we'll come back to the Commissioner conversation.
As Rob mentioned, we are set up to take a vote in January. If the Commissioners are ready to take votes now we can go ahead and move on to that. We'll see how the conversation progresses.

So I saw Melanie and then I saw Bill, and then I see Darin.

COMMISSIONER BELLA: Thanks, Rob. The recommendations make a lot of sense. My comment is not on the recommendation. It's actually, can we go to Slide 17? I just want to clarify one thing. It's the slide that has -- oh, sorry, 20. I got my numbers wrong. The circles.

The New York circle.

So I just want to -- move back to the circles.

Sorry. I just want to make sure I'm understanding. So we're basically saying one of the options for the states is to just redirect what currently is in DSH payment to a base payment and then buy down, in this case, some of the shortfalls. Is that what we're saying that the states could do?

MR. NELB: Yeah. Either a base payment or a non-DSH supplemental payment they could make as well.

COMMISSIONER BELLA: Have we gotten any feedback
MR. NELB: I think the experience we had in Louisiana is sort of the best example that we had, in that it's like theoretically possible and some are considering doing it. It's hard to do, and especially in cases where those payments are financed by providers, shifting around the distribution of the payments may affect the ability of the states to get the same level of IGTs, or the willingness of the providers to pay.

COMMISSIONER BELLA: Yeah, that's where my head was going, just in that case, the ability of the state to really be able to do that with state funds.

CHAIR THOMPSON: So your point is not to overstate, oh well, they could just flip it over here --

COMMISSIONER BELLA: Right.

CHAIR THOMPSON: -- and do this.

COMMISSIONER BELLA: Right.

CHAIR THOMPSON: Right. Uh-huh.

COMMISSIONER BELLA: Maybe some could easier than others.

And then on the third-party payment thing, I just wanted to go on record to say it seems absurd, particularly
in the case of duals. Now what you just said, about the children's hospitals and commercial is a different angle, so maybe we think about parsing it differently. But in the case where it's the Medicaid-Medicare overlap, like it just doesn't make any sense. And so I would encourage that we would include it in the chapter, and then when there is a ruling, hopefully we would make a statement.

CHAIR THOMPSON: Well, that's where I was going, Melanie. I'm sort of like, even though it's a point of litigation, if the issue is some drafting language it doesn't seem to me that that should necessarily preclude us. So I think maybe there is a judgment to be made about how far we want to go with respect to statements about that, because I think there was a reaction of all of the Commissioners to that conversation last time, as well.

Okay. Bill.

COMMISSIONER SCANLON: Yeah, I'm going to start - - I was going to do a comment and a question -- I'm going to start with the question because it's about this third-party payment. I'm confused as to whether it's being applied in the aggregate or on an individual basis. Because when you cite children's hospital, I think if
someone comes in with private insurance are they also going
to be paid by Medicaid and identified as a Medicaid person?
That happens? Okay.

COMMISSIONER GORTON: Medicaid is the secondary
payer. So if your commercial insurance has a big
deductible or a copay, and for families in particular those
can be pretty big numbers, then Medicaid will typically pay
up to the Medicaid limit, and the cost-sharing, and at that
point the hospital can't balance-bill the beneficiary
because they're a Medicaid recipient.

COMMISSIONER SCANLON: Okay. Well, the lack of
balance-billing, that's an issue. But with Medicare and
duals, I mean, the situation is we've got, and for an
inpatient, we've got a fixed deductible, which, you know,
Medicaid could be paying the fixed deductible, but then we
have Medicare payments that are, at this point, on average,
about 10 percent below cost. But that's deliberate
Medicare policy. And so this question of that that now
becomes a Medicaid shortfall, because Medicare has chosen
to pay 10 percent less than cost? That's, I think,

My comment was about, I think I wanted to say
thank you for including the cost adjustment in this recommendation, because I feel like it's an incredibly important precedent. We have historically ignored the fact that there are these very significant cost variations across states, and so therefore you get a federal dollar. What is buys in different states is very, very different. It also goes to the whole question of eligibility, and when we have standards like 100 percent of FPL. It means a very different thing to be living at the poverty level in an expensive state versus sort of a lower-cost state. And so I think this, again, is a very important thing for us to be doing in this process.

CHAIR THOMPSON: Darin and then Alan.

COMMISSIONER GORDON: So, one, to take on with Mellie's comment, when she talked about the ease of raising base rates, obviously there are some complicating factors. Or I should back up -- thank you for all the work you've done on this. I'm very grateful. On that comment that she made about it can be more complicated that they have that as an avenue to raise the base rates, I think that's absolutely valid. But at the same time I also think their ability to transition those to supplemental payments, as
the view on supplemental payments has changed from administration to administration, for the 20-some-odd years I've been involved in Medicaid, so that's not always a given either, what that would look like.

But your point in either, actually, I guess, in the base rate situation is a good one, and everyone needs to recognize it's a complicating factor, that it helps address some of the challenge and loss but there's not a perfect formula to adjust base rates to hold people harmless for the adjustment, so to speak. On the supplemental payment side that could be different, depending on how that's structured. So that was one comment.

I feel comfortable with a lot of your recommendations. One I still struggle with, and I'm not comfortable with, is where we're getting to the point where coverage is not a factor. Just looking historically at disproportionate share hospital payments and it being for uncompensated care, a big factor of uncompensated care is because someone does not have coverage. And the fact that we're not considering that seems -- and I remember the discussions, our discussions, but just from a personal
perspective I have a hard time supporting that, given the history of why disproportionate share hospital payments came into being.

CHAIR THOMPSON: Alan.

COMMISSIONER BELLA: I'm sorry. Can I just ask one quick question?

CHAIR THOMPSON: Yeah.

COMMISSIONER BELLA: This is on, would it be interesting then for us to look at all states in that last column to see how many of their DSH payments are actually going -- I mean, where they're going? Would that be something that -- I guess, Darin, what I'm trying to figure out is have we gotten so far away from intents?

COMMISSIONER GORDON: You're saying try to see how much of it is going for uncompensated care versus --

COMMISSIONER BELLA: Well, the share of payments going to -- well, I'm just trying to figure out, it seems like we've gotten pretty far away from intent, the way some of the payment -- where the payments are going --

COMMISSIONER GORDON: Some of the formulas.

COMMISSIONER BELLA: -- and I was just curious if that's worth looking at.
COMMISSIONER GORDON: Yeah, it's definitely worth looking at. It would be helpful. It's just something --
again, it's a component that, on its face, that I struggle with, and it's one that I have a hard time supporting. But, yeah, additional data may make that more clear to me why that wouldn't be such a big change.

CHAIR THOMPSON: Stacey, you wanted to jump in?

VICE CHAIR LAMPKIN: So I was one of the folks at the last meeting who also preferred the count of uninsured, for some of the reasons that you just said. But going back to original intent was disproportionate share of both uninsured and Medicaid recipients. So, I mean, I got the point about the low-income individuals kind of going back to original intent from that content. Are you --

COMMISSIONER GORDON: I'm saying excluding the one doesn't feel right, the uninsured component, and that's what I took the third recommendation as that coverage is not a factor any longer, in the recommendation, and uninsured, I think, should be a factor, continue to be a factor.

CHAIR THOMPSON: Yeah. I mean, the discussion that we had last time, which I thought was interesting too,
was a little bit about this issue of there's a lot of different reactions and choices that states can be making, taking into account what they're getting in terms of DSH funding. So we talked a little bit about you can get money to hospitals through different avenues. You can also reduce some of the need by coverage choices, of varying kinds, that states have made over the years and continue to have in front of them. And I think part of the issue was to try to avoid disincentivizing or incentivizing any one of those particular policy levers or recognition that all of those become available to states to make some of the decisions, and that the low-income population, which has a higher proportion of Medicaid coverage, has a higher proportion of uninsured rates, was kind of a neutral element of population attributes that could be used to make some of these decisions. So that still may not be compelling to you, Darin, but that was --

COMMISSIONER GORDON: No. I mean, all valid points. So when we did TennCare back in the day we got rid of our DSH, and the intent behind getting rid of our DSH wasn't because, you know, it wasn't that your Medicaid loss goes down. In fact, we're going to cover more people on
Medicaid. It was a reduction in the uninsured population.

Now, granted, it was not a wise decision back then to completely get rid of your entire DSH, as others, the ACA, got it that, you know, just because you have 100 percent coverage, even in a place where you would have 100 percent coverage, you're still going to have some uncompensated care at facilities, and Massachusetts saw the same thing.

I hear you. My point being, though, is the uninsured is a big factor in what those hospitals are doing with uncompensated, and regardless of what we do, I am convinced every policy I've ever made creates incentives and disincentives. Not doing it creates incentives and disincentives as well.

CHAIR THOMPSON: Anne is looking to jump in.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah. I just want to jump in to remind you that at this level we're talking about distributing a pot of money across states, so it's about where states sit relative to each other. And it's also, when you will recall the last meeting, Rob had these three different measures and their correlation with uncompensated care costs, and none of them were head and shoulders above the rest.
So I think that's worth thinking about. When you do it based on the uninsured, it's not like it takes you much, much closer to some nirvana of deciding who needs it most. But keeping in mind both of those things, the distribution and the fact that none of these measures were incredibly highly correlated or preferable to each other from that perspective.

CHAIR THOMPSON: And this one was actually the one in the middle, in terms of level of correlation.

COMMISSIONER GORTON: And let me just ask, Anne, would you then contemplate, in the rationale that went with the recommendation, to say precisely that, and essentially give the pros and cons?

EXECUTIVE DIRECTOR SCHWARTZ: Absolutely. Absolutely.

COMMISSIONER GORTON: So that we would say you could, in some ways, the uninsured population felt, to many Commissioners, as being closer to the original intent, but it wasn't a better measure and it's subject to coverage decisions by individual states. And so, in the end, we gravitated towards the low-income number, but arguments can be made. I mean, do we have to be that specific about this
indicator in this recommendation, or can we say, look,
there are no perfect choices. There aren't even any really
good choices. But, you know, we think the least bad of the
choices is this one.

EXECUTIVE DIRECTOR SCHWARTZ: I will answer that
in two parts. One is we absolutely can and should in any
rationale describe the Commission's decision-making
process. My caution would be in not recommending something
is that if you want Congress to do something that you think
is better, then I think if you can come to a decision that
would be based on data, that would be our value add here as
opposed to what we might imagine Members of Congress
gravitating to.

CHAIR THOMPSON: Yeah.

EXECUTIVE DIRECTOR SCHWARTZ: So that's a two-
part answer.

CHAIR THOMPSON: I'll just reinforce that idea.

I think as much as possible our contribution is to have the
Commissioners weigh in on what seems on the basis of the
evidence better or not as good. If we're saying, well, you
know, just in general it should be -- you should think
about something or in general it could be different, I
think that's understanding that people already have.

COMMISSIONER GORDON: And I get, Anne, your point about it should be in funds across all states. I mean, I worked on these formulas in the late 1990s and early two -- and this very question came up quite often in the creation of our formulas on distribution, is like how do you weight the uninsured factor, the uncompensated care factor, and the Medicaid loss factor? And it wasn't one's 100 percent and the other is zero. We weighted uncompensated care higher than the Medicaid loss, but they were both a factor. So that's my point, and, again, it's just born out of a long history of messing with these things. They are messy, I'll just say that.

CHAIR THOMPSON: Let me ask Alan and then Fred to weigh in, and then we'll go to the public to circle back around.

COMMISSIONER WEIL: So I initially had my hand up for a slightly separate topic, so I'm going to try to cover them both quickly.

I am a little worried about where this conversation is going, talking about perfect or imperfection or alignment. This is a value choice about
whether allocation should be based on need as defined by uncompensated care. Then there's a question of is it -- how perfectly can we measure uncompensated care? Or should it be based on need as defined by the inherent demographics of a state?

For me, the reason I support this language in the recommendation is because I believe need is based on inherent characteristics, not on trying to measure something that we can only measure imperfectly. So I find the perfection language not to fit the way I think about it. I'm not saying it's right or wrong. I just think there are two different ways to think about this, and I don't want us to just think about it as, well, there's a correlation and we picked the one with the closest correlation, because this is really a value statement about what we think underlying need is.

I'm going to toss out, just to be annoying -- I have to say, Bill, your comment made me realize there's some real complexity in the phrase "after adjusting for differences in cost" that I don't actually think we've grappled with because the way you said it, there are actually a lot of different ways of thinking about what
that means. One is to say the DSH allocation should be
adjusted by the input factors. But we know that
eligibility -- well, we know that larger -- lower-income
states have higher rates of Medicaid coverage because of
standardized eligibility. We also know that DSH is
matched, and the matching formula takes into account state
income characteristics.

We are not writing statute here, and all we're
saying is that Congress should tell HHS to do it. But I
actually think the phrase "after adjusting for differences"
is really ambiguous, and I'm not sure how quickly we can
figure out what we mean by it, but I actually don't -- I'm
in favor of it, but I'm not sure at this point I even quite
know what we mean by it.

CHAIR THOMPSON: Bill, do you want to jump in?

COMMISSIONER SCANLON: I think we definitely have
to explain exactly what we're doing, but some of these
other factors that you talked about are already being
incorporated, and this is one that has been left out
historically all the time. We do not recognize that there
are differences in input costs that are going to -- that
are significant and are going to affect the volume of
services that are financed out of a given set of dollars.

CHAIR THOMPSON: Rob, do you want to jump into this conversation since you would be the person writing the description of what we mean by this?

MR. NELB: Sure, and I guess I would just note that, you know, we tried to sort of massage the language for that actual recommendation the best we could, but remember that accompanying the recommendation is the rationale and then that design consideration section. So in that design consideration section is where we tried to explain the methodology that we used, which was based on the Medicare Wage Index. Then I also included some references to the fact that there are, you know, differences in different poverty measures and things, but since this doesn't have a formal state-by-state adjuster that you can easily plug into the formula. So that I'm open to any ideas to tweaks of the language, but I wanted to suggest that the design consideration section might be a spot where we could have a few more sentences to describe what we really mean, and that might be more useful for the drafters.

CHAIR THOMPSON: Fred.
COMMISSIONER CERISE: Thanks. So, first, I'll comment without trying to prolong the discussion of the uninsured too much longer. I do think some comment about that -- and I think Rob did a good job. I'm reading what you had on page 7 of the report that you acknowledge that that is an issue, because I don't think there's uniform agreement on that point, which you're not going to get, and I recognize that. I think it's much better than status quo, but the truth is the uninsured is a huge issue there with uncompensated care costs that the hospitals feel, and so to at least acknowledge that and say states have the ability to affect this. States can make a decision and can impact that. But I do think some reference or discussion of that would be helpful.

A couple of other things. I think you guys have said a lot about the Medicaid loss, the shortfall, and I agree with that.

Rob, in your text you talked about some other -- it sounded like more minor things, but things that may, as you maybe tweak the leftover funds or something, the hospitals -- the states that target more towards deemed hospitals may be a factor there, sort of more of a minor
factor. I don't exactly remember how you included that, but it was raised as a question of, you know, do you want to comment on that? And I don't know if you can do this. When you look at the targeting of deemed hospitals, it doesn't really reflect reality in a lot of situations because of the way states use IGT. And so you will see this targeting where it's not really targeting. And so I don't know if it's possible to tease that out and to show targeting after you've teased out the IGT to see, you know, if states really are targeting or spreading, because I think some of those states that look like they're targeting are really spreading more than it appears.

And then, finally, the California global payment thing, I think particularly since states may have a little more flexibility to address the Medicaid shortfall with rates and things like that, and less so the uninsured, although you've got the ability to do both, I wouldn't necessarily throw that out as something not to consider or to comment on just because, you know, I'm interested to see how that plays out and if it is an option to replace some of these things in a coordinated system of care, I think it would be worth commenting on.
CHAIR THOMPSON: Okay. Why don't we go to the public and see if there's any commentary?

### PUBLIC COMMENT

* MS. GONTSCAROW: Hi. Good afternoon. My name is Zina Gontscharow with America's Essential Hospitals, and we really appreciate the Commission and staff's hard work around DSH payments and the thoughtful consideration of ways to soften the blow of the impeding DSH reductions on states and hospitals. However, we really encourage the Commission to include in its recommendations to clearly state how devastating that these cuts would be and the magnitude of these cuts would really have a great impact on hospitals, especially essential hospitals across the country.

In addition, we appreciate the conversation and recognition that it is a little difficult for states to just quickly turn around and use another funding stream to support these hospitals, and we encourage the Commission to make that really clear in its recommendations.

Thank you very much. We appreciate the opportunity to comment.

CHAIR THOMPSON: Good. Thank you.
Any other comments?

[No response.]

CHAIR THOMPSON: Let me just go back for a process for a second. So, Rob, are you going to have a draft chapter along with -- based on this feedback, recommendations, rationale, et cetera, for us to review for the January meeting at the time that we're planning to take a vote?

MR. NELB: Yes, that's our plan for that. We have the UPL one we're going to talk about later. We have the draft chapter done, but I'm only one person, so the other draft chapter is coming in January.

CHAIR THOMPSON: Brian, are you jumping in?

COMMISSIONER BURWELL: I just have a clarifying question on Recommendation 2 and how the algebra around the unspent funds is going to work. So I'm just trying to be simple here. So I'm a state that gets $100 million in DSH funding per year. The reductions make it that I'm going to only get 80 the first year, but I also have $50 million in unspent funds. So do I only get $30 million that year because I have $50 million in unspent funds?

MR. NELB: Sure, so I had to work through the
MR. NELB: The formula we were thinking of is, you know, there's that $1.2 billion in unspent funds, and basically sort of before we start applying reductions that are based on this rebasing methodology, we cut from that $1.2 billion first. So what it effectively does is it reduces the amount of cuts for other states in that first year.

COMMISSIONER BURWELL: But it's applied on a state-by-state basis, these unspent funds have been -- are divided.

MR. NELB: So, yeah, for each state we projected the amount of funds that would be unspent in 2020, for example, and then --

COMMISSIONER BURWELL: So you have to spend your unspent funds --

MR. NELB: Another way is that we're doing --

EXECUTIVE DIRECTOR SCHWARTZ: Don't you take them off the top, Rob?

MR. NELB: Yeah.

EXECUTIVE DIRECTOR SCHWARTZ: Like you're
basically adding them all up, you take them off the top first, and then you take the amount that remains and distribute that around to the states. So the pool of cuts is -- the total pool is smaller by that amount.

MR. NELB: And the other piece is that --

COMMISSIONER BURWELL: Does that change the total amount of reductions over the entire period?

MR. NELB: No, so we're still at the $2 billion, $4 billion, $6 billion, and $8 billion.

COMMISSIONER BURWELL: So that 1.2 counts towards the $2 billion, basically.

MR. NELB: Yes.

COMMISSIONER BURWELL: And so the actual amount of reductions, real reductions is less.

MR. NELB: The net effect of the reductions is less.

COMMISSIONER BURWELL: I got it.

CHAIR THOMPSON: Okay. So I think what we have is -- I want to come back to one point. So we've given you some feedback about some of the discussion that we want to have. I think if you can come back with more on third-party payments, people are ready on that subject. And, you
know, some of the additional parsing and understanding I think would be helpful to the Commission on that in terms of considering potentially a fourth recommendation. It's also possible that we could just decide that we'll have a longer discussion of it. We may feel like we're not ready to get to a recommendation. We can kind of decide at that point whether it's just a matter of we want to point out a place of concern or attention from the Commission without making a formal recommendation.

I do want to consider how we handle -- so we'll give this some thought. I think there is a general view that the recommendations as written are right, but I do recognize that there are places where Commissioners may have some different preferences, and I want to think about how we -- we've talked about voting on this as a package, but I want to be sure that if Commissioners have some things that they want to say, for example, around this issue that we discussed a little bit around, you know, the low-income side versus the uncompensated care, that we appropriately give Commissioners the room to say what they want to say about that. So let's think a little bit about -- you know, it may be a matter of in the voting that we
want to be sure that if people want to express that they
would have preferred a different way that we want to invite
people to say that, and we'll be sure to reflect that as we
write up the vote, that there might have been a group of
Commissioners who would have preferred a different
methodology with respect to Recommendation 3. I just want
to allow for that so that the Congress has that information
fully reflective.

Okay. Any other last points on this topic?

[No response.]

CHAIR THOMPSON: We're satisfied on that, and
thank you, Rob. We'll look forward to that chapter and
vote in January.

Let's go ahead and move directly into UPL.

### UPPER PAYMENT LIMITS FOR HOSPITALS: PROPOSED

RECOMMENDATIONS TO IMPROVE COMPLIANCE

* MR. NELB: Great. So I am back for more. So now
we're going to look at another set of proposed
recommendations related to upper payment limits for
hospitals, known as the UPL. I'll begin by providing some
background on UPL payments and then review some of the
findings that I discussed with you in September related to
UPL compliance. And then I'll share a package of two
recommendations: first, recommending that CMS develop a
process to certify that UPL data are accurate and complete;
and, second, recommending that CMS make UPL data publicly
available.

Just like when we discussed the DSH
recommendations, here I'll be looking for your comments on
the recommendations themselves as well as the rationale
that will accompany the recommendations.

And then, finally, we'll conclude by talking
about next steps for this chapter and for potential future
work on UPL payment policy.

So, first on background, as you know, the UPL is
an upper limit on aggregate fee-for-service payments for a
class of providers, and it's based on a reasonable estimate
of what Medicare would have paid for the same service. If
Medicaid base payments are below the UPL, then states are
allowed to make UPL supplemental payments to help make up
that difference.

States can make UPL payments to a variety of
different provider types, including hospitals, nursing
facilities, and physicians, but the vast majority of UPL
payments are made to hospitals. So in 2017, for example, $13.1 billion in UPL payments were made to hospitals compared to $4.3 billion in UPL payments to other provider types.

In 2013, CMS issued guidance requiring states to demonstrate compliance with the UPL annually. Previously, states would only demonstrate compliance with the UPL when they came in to make changes to their Medicaid state plan.

To help states comply with these new requirements, CMS developed templates for states to submit provider-level data in a standard format. These templates have been optional for states since 2014 and are now required for all states.

This past summer, we obtained hospital-level UPL data for state fiscal year 2016 for 47 states and the District of Columbia. To better understand these data, we compared them to actual spending reported to CMS, and we also spoke with CMS and several state officials about our findings.

While we initially reviewed these data to inform sort of our ongoing work on hospital payment, our analyses identified several sort of more immediate concerns related
to just the accuracy and completeness of the data used to 
monitor compliance with UPL requirements.

Specifically, we found some pretty large 
discrepancies between actual and reported spending, and in 
some cases these discrepancies were so large that they 
raised concerns that some states may have made payments in 
excess of the UPL. Specifically, we found that in 17 
states the actual amount of UPL payments in state fiscal 
year 2016 exceeded the UPL limits that were calculated on 
the UPL demonstrations by $2.2 billion in the aggregate.

When we shared these findings with states and CMS 
officials, they couldn't fully explain the differences that 
we observed. CMS officials for their part, you know, do 
expect states to be submitting accurate data on these UPL 
demos. But the states that we spoke with noted that they 
were still waiting for feedback from CMS about whether 
their calculations were correct. And, ultimately, we 
learned that there's really no process to certify these 
data after they're submitted to make sure that they're 
accurate and complete. And the lack of sort of finalizing 
what the actual UPL limit is limits the ability of states 
and CMS to actually use these UPL limits when they are
reviewing claimed expenditures.

Lastly, during our review we also looked at the methods that states currently use to calculate the UPL, and of note, we found that many states currently use cost-based methods that appear to result in limits that are higher than what Medicare would have paid. However, we don't have enough data at this time to quantify the amount by which the UPL is higher than what Medicare would have paid.

So to help begin to address some of these concerns that we identified, we're proposing two recommendations. The first one here reads as follows: The Secretary of the U.S. Department of Health and Human Services should establish a process to certify that annual hospital UPL demonstration data are accurate and complete so that states and HHS could use the limits calculated with these data to ensure that actual spending is below the UPL.

The rationale for this recommendation really begins with the underlying purpose of the UPL, which is to provide an upper limit on Medicaid payments to providers. If UPL limits aren't being enforced when the payments are being made, then they aren't achieving their purpose of having an upper limit.
CMS already has existing regulations that require state spending to be below the UPL, and CMS regulations also give it the authority to defer federal funding for spending that exceeds the UPL. However, the gap that we found is that it's challenging for CMS to sort of enforce these requirements because the data that it collects to monitor UPL compliance isn't reliable.

As I mentioned, in the years that we looked at, we found examples of billions of dollars of payments that were missing, and we also found large discrepancies in the payment data that were reported.

So our thought is that establishing a process to certify that the UPL demonstration data are accurate and complete is an important first step towards making these data more reliable and more usable to enforce the UPL.

This recommendation doesn't prescribe a specific process for CMS to follow, and so it's open-ended about whether that certification process could be done by states, by CMS, or by an independent entity.

However, in our rationale, we note that we encourage CMS to consider approaches that minimize the risk that UPL payments are recouped retrospectively from
providers, since we know that UPL payments are an important source of revenue for many hospitals.

Also, regardless of whether states or CMS are the ones that are certifying the UPL data, we recognize that both states and CMS have a joint responsibility to ensure that claimed expenditures are consistent with federal requirements.

The ultimate impact of this recommendation depends on whether CMS continues to find evidence of UPL overpayments after reviewing more accurate and complete data. If so, CMS could recoup excess payments to providers using its existing deferral process. However, CBO won't assume any federal budget savings from this proposal since it's really intended to enforce existing law.

Depending on how the policy is implemented, states or CMS may have some increases administrative effort. Currently, CMS estimates that the existing inpatient and outpatient UPL templates require about 80 hours of state staff time to compete per response.

In terms of the effect on providers and enrollees, providers could be affected if it is found that they received payments in excess of the UPL, and then the
corresponding effect on enrollees will, of course, depending on how provider respond, if there are cuts in UPL payments.

All right. The next recommendation that we're proposing has to deal with transparency. Specifically, the recommendation reads: "To help inform the development of payment methods that promote efficiency and economy, the Secretary of HHS should make hospital UPL demonstration data and methods publicly available in a standard format that enables analysis."

Since UPL payments are such a large part of Medicaid payments to hospitals, it is important to understand where this money is going. In 2017, UPL payments were actually larger than DSH payments to hospitals, but unlike DSH payments where they're audited annually and we have that publicly available data, unfortunately we don't have any public data on how UPL payments are spent.

This recommendation builds on MACPAC's prior recommendations for more transparency in Medicaid payments to hospitals. While we would ultimately like complete data about all types of Medicaid payments, we recognize that the
UPL demonstrations are an existing data source that can fill an important gap without creating a new reporting system for states and CMS.

MACPAC's interest in these data is not just only for transparency but also to help inform the development of payment policies that promote the statutory goals of economy and efficiency. For example, more complete data about UPL payments that states make can help inform analyses about whether these payments are well targeted and can help inform our understanding of how they relate to other types of payments to hospitals.

The effects of the second recommendation are relatively limited, since states are already providing this information to CMS; however, there may be some increased administrative effort required for CMS to post reports publicly. But this change isn't expected to change federal spending.

So that concludes my presentation for today.

Similar to the DSH recommendations, our initial plan is to vote on these at the January meeting and to accompany the recommendations with a report chapter that describes the Commission's analyses and findings.
You have a draft of this chapter in your materials today, and so I also welcome any feedback you have about the tone, messages, or major conclusions of that chapter.

In that report chapter, I just wanted to highlight that we provided a little more background information about the methods that states use to calculate the UPL. At the September meeting, some Commissioners flagged this might be an area for future work, and so I welcome any thoughts you have about more that we can do in that area.

Thanks.

CHAIR THOMPSON: Great. Okay. I'll jump in first. Then I've got Kit and Darin.

I'm having trouble with the first recommendation talking about certification because what certification is somebody saying I attest this is full and complete and accurate, and it's only the state that can do that because that's the state's submission to CMS.

I think our issue is that -- and I'm not even sure if it's a matter of are we concerned about certification, per se. It seems like what we're concerned
about is that the states submit the information and that
they get feedback from CMS and that they finalize the
information, and then that CMS use that information. And
I'm not sure that that's what reflected in the use of the
term "certification."

I'll see if other Commissioners have comments on
that, but it seems to me that what we want is we want
states to submit the UPL demonstration to get feedback from
CMS to finalize it, and in so finalizing, they may certify,
as they do sign statements on a variety of different things
that they send to the federal government about like this is
ture and accurate to the best of my belief and knowledge.
Then we want to be sure that part of that is also
that CMS actually consult those data when they are
approving state claims for financial match. So it seems
like that's what we want to have happen, and I'm not sure
the way that we've written it is exactly conveying that.

EXECUTIVE DIRECTOR SCHWARTZ: Can I just ask a
quick question?
CHAIR THOMPSON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Which is for the
purposes of this recommendation, I think what you're
talking about is exactly what the staff was trying to achieve. If we just subbed out the word "ensure" and "for certify," if "certify" is like too specific a word with too specific a connotation, and then what's described in the paper gets --

CHAIR THOMPSON: Yeah, that might do it. That might do it, yeah.

I do think that the word "certify" does have, especially in the financial world --

EXECUTIVE DIRECTOR SCHWARTZ: That's fine. I just was trying to figure out --

CHAIR THOMPSON: -- a very specific connotation.

EXECUTIVE DIRECTOR SCHWARTZ: -- if there was an easy fix.

CHAIR THOMPSON: Yeah.

Okay. Kit, Darin.

COMMISSIONER GORTON: So my reaction to the chapter was that you wrote a pretty compelling argument for why things should change in a fairly major way because potentially billions of dollars of federal money are being misspent.

My reaction to the recommendations are that they
don't rise to the level of response that I think we should be recommending for what could be a fairly substantial problem.

And you've outlined beautifully in your presentation and in the chapter, problem number one is we have no idea how big the problem is because the states don't calculate the limits correctly, and CMS doesn't enforce the limits that they approve, and money just goes. And you are a very gifted and talented analyst, but there's only one of you. And it only took you a few months to figure out that we might have billions of dollars of overspent federal funds.

I'm willing to bet that if we gave you and a small army of people a little more time, you would find out in addition that there's huge variation state by state, and that some of the states are being choir girls and boy scouts, and they're doing it. And they're probably under-clubbing it, and so they're getting less than they might get otherwise. And other states are just being very, very creative and assertive in their methodologies, and they're using this frankly as an unmetered piggybank.

And given the size of this spent and the lack of
accountability, where I came from at the end of reading the chapter was we should be recommending some pretty heady stuff.

And I don't know about the technicalities about certify. Should CMS have a process? Yes. They put out templates. That's good. Should they make sure the states fill out the templates right? Yes. Should we make sure that the states get to the right number? Yes. Should we then say that UPL, the "L" stands for "limit." And we wouldn't have to worry about provider recoupments if the states weren't overspending the limit in the first place, right? So there ought to be some process controls in place that keep states within their budgets, like the rest of us have to do, right? If we go bouncing checks all over the place, you don't get to go back to the electric company and say, "Oh, I need that money back because I didn't have it to give to you."

The providers shouldn't take it on the chin here; it's the states need to administer the program correctly. And so it seems to me I won't quibble about these, except to say that it really seems to me to be just much too limited response to what seems to be a potential big
I know we can't characterize this as a saver from the perspective of the budget, but I think we could probably save a fair amount of money for the taxpayers if it weren't being spent in this way.

And at the very least, even if these expenditures are just and reasonable, then we ought to be able to look at them and say, "Yes, we're proud of how that works. We're glad that we're doing it this way, and it's okay."

So I personally would like to see recommendations about CMS holding states accountable. I would like to see a recommendation about states doing it right and then living within the math that they calculated. I understand all the vagaries about perspective and a lot, and they can't estimate utilization patterns in advance and those sorts of things.

But there's an actuarial exercise that could be done, and I think we could come a whole lot closer. I mean, if the managed care rates were off by billions of dollars, there would be a hue and cry. So it seems to me that we could require the states to come closer to this.

And then the other place that I would like to
potentially see a recommendation is to Congress to exercise
its oversight or at least -- and in doing that, yes, the
Secretary should do these things and should report to
Congress what the findings are, have we sorted this all
out. Congress needs to hold the Secretary accountable that
he has done -- or whoever it is has done what they need to
do in terms of overseeing what you have described as being
over 50 percent of the Medicaid hospitals.

CHAIR THOMPSON: Let me just jump in. I enjoyed
that.

COMMISSIONER GORTON: I do try to be
entertaining.

[Laughter.]

CHAIR THOMPSON: As somebody whose hair went on
fire the first time Rob brought this forward. But what I
would say, Kit, though, is my perspective is, in a lot of
instances, issues that reflect financial vulnerabilities
have their answers in very boring, pedestrian management
controls and processes, and so there are a variety of
requirements on states that don't require them to
necessarily disclose and report every aspect or detail of
how they do something to the federal government.
The only reason that there was even this requirement for annual reporting of UPL was because there had been some problems in the past with states who had had UPLs that kind of reset over time on an automatic basis, and that was not something that ever was subject to federal scrutiny because it was automatic. And those kinds of payments never came up in the context of other state plan amendments and waivers.

And so the idea of submitting something on an annual basis was something that was in response to an identified vulnerability, right? That we aren't looking at these things more frequently, and it's one of the things, because it is such a central control, that we ought to be looking at more frequently.

I think that there is a process here whereby submitting these data, making sure that they are complete, making sure that they're finalized, making sure that they're then applied to scrutiny over the financial expenditures themselves that will in fact solve the problem. And I think we thought we had kind of maybe solved the problem before, and now we find that, well, we didn't quite clean it up in all the ways that we thought we
were going to clean it up, and we didn't quite dot the i's
and cross the t's.

My view would be also to try to get this settled
into a routine and an operational approach that ensures
that, you know, the importance of the information is
appreciated, the importance of using the information is
appreciated, and I think in the end, that will accomplish
many of the things that you're talking about trying to
accomplish.

So I think even though the recommendations come
off, perhaps, as kind of like, "Well, yeah, this is what
you should do," I actually think they will accomplish what
it is that we hope that they will.

COMMISSIONER GORTON: I think they may to some
extent, and obviously a well-operated process of controls
would -- and it's not rocket science that we're talking
about.

Rob has pulled the curtain back, and what we've
seen is that what was built was not enough for a variety of
reasons. The states can't price it -- if states can't
price it right, then they can't do the calculations right,
and if they don't have to live within the calculations --
so I do think that what we need is a bunch --

CHAIR THOMPSON: Well, we don't know the reality. I mean, that's the thing because we're missing -- what we have is the absence of the management control, which gives us the confidence, not -- but we don't know, in absence of that management control, it may be some things are fine. It's just that we don't have the information and the assurances that we ought to and that we've already demonstrated to be necessary.

COMMISSIONER GORTON: Yes. But it's because I think we're missing controls.

CHAIR THOMPSON: Yeah.

COMMISSIONER GORTON: And I think we're missing several layers of control, and I would just like us to have the Secretary beef up his controls. I would like to have the states -- I mean, certify is good. It does make people pause when they have to sign something and say, "I know this is right." But I think there are controls -- there are detail controls that can be put in place that sort of force the states -- and the templates probably help -- that force the states to go through the exercise and do it properly. There are process controls. Can they price the
claims? Do they have access to the Medicare pricing so that they can actually price the claims, which it sounds like some of them are not pricing them?

CHAIR THOMPSON: Yeah. That's --

COMMISSIONER GORTON: So just let me finish my thought, and I'll shut up. Sorry.

But as well, then CMS needs to make sure they did it right. States will struggle. They don't have resource. They need to make sure they did it right, and then they need to hold them accountable to that. And then Congress needs to hold CMS accountable for the whole mess, and so I think there are those three levels of accountability. I don't think there are enough management controls in any of those levels, and I would like to see us go fairly far in saying this is what you need to do. I'm not talking about anything more than that.

CHAIR THOMPSON: I want to get the other Commissioners in here.

I do think in terms of the question of how do you calculate the UPL, I think it's important we put down the marker that we want to do more work on the how.

So some of the things that are about what data
are you using, is it really the right data, does that sort of -- we talked before about some broad assumptions that are being made perhaps in some of the UPL demonstration. Maybe we should pay attention to that and take a look at it.

I do want to acknowledge that we have some other things, other than this, which was simply about you have not really closed the loop on something that you initiated as a management control to ensure that you had the information on the UPL and that you were using it.

Darin and then Alan.

Anne, you were trying to get in. Was there something you wanted to say about --

EXECUTIVE DIRECTOR SCHWARTZ: No. I was just going to say to Kit that I think all that was what the intent of the chapter was minus the outrage. That one of the press reports recently called MACPAC "cautious and sober," and I think we were trying more on that tone. But the intent --

COMMISSIONER GORTON: So this would be outrage.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah.

CHAIR THOMPSON: Okay. Darin.
COMMISSIONER GORDON: So this will be far less colorful.

Do we have a sense of what was driving the situations where there were UPLs paid in excess of what the calculations indicated? Was it timing of reports, timing of data? Was it poor processes?

A little bit to what Penny is saying, I think there are some questions I have about there's definitely -- it sounds like your recommendations are a start in a process, and that's just one of the questions I want to know right -- first off, if you have any sense of that.

MR. NELB: Sure. So I think part of the thing is we found there were missing payments and missing hospitals -- missing payments, so, first of all, you know, UPL demonstrations are supposed to calculate that base payments as well as the UPL supplemental payments are below the UPL. But then some states didn't include what their UPL supplemental payments were. And when you put in what their actual UPL payments that they spent were, it was above what they calculated their UPL to be. So first it was just like tracking the actual UPL supplemental payments on these UPL demonstrations as a piece.
Another area is we noticed some missing hospitals. There may be some reasons, like for critical access hospitals that are -- other ones that are paid on a cost basis, reasons why they might be excluded. But sort of clearly understanding what's included and not and figuring out a way to track that, and even if those hospitals aren't subject to the UPL, being able to know, you know, what payments are being made to them so you can kind of complete the whole picture and compare it with the state-level data that's on expenditure reports.

And then there is a piece -- a lot of these demos are submitted prospectively, and then we were looking at what their actual data was.

COMMISSIONER GORDON: Okay, so multiple factors, which I suspect. I like the recommendation. I think that's a good start. I do think it probably won't be where we end because you give more information and figure out how to go deeper than that.

I like your transparency one in particular, and one thought, kind of merging your two presentations, you don't have really good data on what they're doing on the UPL side. Then how do you know that it's being backed out
in the DSH calculation on the Medicaid shortfall side?

MR. NELB: So UPL payments are included in DSH audits, but we only have DSH audits for hospitals that receive DSH payments. So there is another -- you know, only half of hospitals receive DSH payments, and so for that other half, we don't know what they're receiving.

The other piece is that on DSH audits it doesn't distinguish between fee-for-service or a managed care base payment, and so the number is sort of -- we can't quite fully match up. But, you know, when we made our previous recommendation around just more transparency in hospital payment in general, I think we had noted that, you know, you could sort of build off what you're already collecting on the DSH audit side, you know, to -- because all those payments are supposed to be captured on the DSH audits, but they're just not presented in a way that we can tease apart, and they're not reported for all hospitals, which is needed to kind of get the full picture of what's happening in a state.

COMMISSIONER GORDON: Remind me of the frequency on the DSH audits.

MR. NELB: They're annual, but there's a data
COMMISSIONER GORDON: Are they in every state?

MR. NELB: Yeah, every state has to submit it annually, but there's a data lag of about four years.

COMMISSIONER GORDON: I don't remember doing it every year, but I remember there was an extensive one while I was still there.

MR. NELB: Yeah, because there were new rules sort of requiring a more rigorous audit, 2010 or 2011 was maybe the first that --

COMMISSIONER GORDON: Okay. Thank you.

CHAIR THOMPSON: Alan, were you getting in next?

I didn't write you down, but I think you were in line.

COMMISSIONER WEIL: Thank you. I just want to distance myself from the outrage. I think it's great you pulled the curtain back, and I think there are some questions that need to be answered. Kind of like with DSH and lots of other issues we work with here, the infrastructure of data in this system is not up to the task of management. Finding another curtain to pull back and finding another place is disappointing but not shocking.

I would hope our role, in addition to the
transparency and goal of improving the data, is to think about this in the context of the payment issues that we have discussed at some length. I think the underlying policy here, again, like many in Medicaid, has some conceptual basis and some practical mismatch. And so the reason I want to distance myself from outrage is I would -- as a Commission, I would like us to be -- what was it? -- sober and cautious, because I don't think we know, at least based on what you presented to us, I don't think we know what's going on here. I don't want to sound an alarm. I think it's very important we find out what's going on here, but it may well be that what we find out here drives us to suggest a different way of thinking about UPL, and that would be a very important and exciting and challenging thing to do. Like DSH, anything that looks at these payment systems has potential disruption. That's where I would -- so I'm holding my outrage for the time when we reach a conclusion that this conceptual notion that, of course, payments shouldn't exceed cost actually requires a different way of thinking about it, given how much has changed since some of these provisions were put in place. So no desire to hold back on the goal of
transparency, and, again, really alarming. Don't mean to minimize the alarm, but I'd rather be -- at this point I'm alarmed, not outraged. Let me put it that way.

CHAIR THOMPSON: Toby and then Brian.

COMMISSIONER DOUGLAS: Following on Alan, you know, I also am cautious on this, given a lot of times the states as well as CMS were moving too fast, and the right hand doesn't know what the left hand -- and you do one process, and the next process happens, and they don't come back together. And that gets to the first recommendation, and, you know, clearly the goal here is to align and ensure the payments don't exceed the UPL. For deference to CMS, I just question whether we need to be so specific on this issue of the certification and more -- the goal, again, here, back to, you know, my view of things are moving too fast, is that CMS in consultation with the states needs to develop a process that could include or should include some -- whether we use the word "certification," but ensuring the UPL is complete, a complete process that ensures that the payments are tied back to the UPL and reported out in a transparent fashion.

But I just wonder, given there's also resource
issues here, that CMS might need state -- that we don't
give a little bit of -- that the recommendation leaves it
open on what is that process, what are all the pieces to
ensure we get to the end game and don't -- and ensure that
Kit's not outraged.

CHAIR THOMPSON: The other point to consider is
whether or not -- I don't know if CMS actually has the
authority to require states to certify the UPL
demonstrations as they've come in. And so, I mean, it's a
question, you know, whether that would require some kind of
regulatory thing. I don't know if it's a PRA issue. There
are always those kinds of worries. So just apropos of your
point about saying, you know, we need something to ensure
certain things happen.

Okay. Brian and then Sheldon.

COMMISSIONER BURWELL: So I assume that this may
turn into a chapter in June or whatever -- March, and go
out to the general public. I think a lot of people who
read this chapter will learn a lot about it, but it may --
you know, I think a lot of people will have the question,
like, "Why do we have a UPL financing mechanism for
hospitals at all? This doesn't make any sense to me. They
can just pay higher base rates."

Now, there are many reasons for the answer to that, but I think the chapter should get into that a little more. I mean, people have talked about that here, but what kinds of disruption would happen in the states if the UPL payment went away? My understanding is it has a lot to do with where the state financing comes from. We should talk about that in the report.

And I'm also wondering if Recommendation 2 includes more transparency about this financing of the state's share. Do we get that data at all in state reporting?

MR. NELB: The data is not currently part of the UPL demonstrations that states submit. It is part of -- the Commission's prior recommendation around hospital payment also included a recommendation to collect information on the sources of non-federal share, but that would require a new process that CMS isn't doing today.

CHAIR THOMPSON: So just to respond to Brian's point then, we've generally made this comment that we want to see more hospital-level data and we want to see that come alongside of any financing information as well. So we
could, you know, footnote that and so forth. I mean, I do think that there's room here for us in the future as we've talked about, some of the points that have already been made in terms of looking underneath of how good is the actual data and demonstration underneath of this, and even how does this accomplish this overall goal and what do we think this goal is worthy. I mean, so we have more things to kind of think about there. I think here we're trying to clean up something that we kind of stumbled upon, right? Which was in the course of collecting this for the purposes of informing our larger hospital payment project, we found, oh, we can't rely on this data. And so I think, you know, just to remind the Commissioners, we have opportunities to kind of come at some of these other questions in the future. We are just trying to focus on a particular problem that we've identified, which is not necessarily -- wasn't necessarily what we intended to identify, but something that we feel needs to be rectified moving forward.

Okay, Sheldon.

COMMISSIONER RETCHIN: Well, I do want to start by saying I am going to remain cautious, but I'm going to
distance myself from sober.

[Laughter.]

COMMISSIONER RETCHIN: So, Rob, one thing, I have one question. Listen, I am all for transparency and trying to align the costs, the reported costs, pull back the curtain, looking to understand the UPL payment and realizing the cost. But just to make sure before I make a comment, Rob, there are no other technical reasons that the payments and costs are mismatched like the genesis of the non-federal share, that's not -- is that a --

MR. NELB: No, yeah, the states are subject to the UPL based on their total state and federal costs, regardless of how they finance the payments.

COMMISSIONER RETCHIN: Okay. So I'll probably be an outlier in this, but in addition to the transparency, going back to the DSH discussion, these two sources of how we underpin our safety net system, I'm going to lament that we're not also moving to think about these two sources as we cut of trying to get ahead onto some sort of a payment and delivery reform. And I go back to the California experiment with global payment program, and so before we start with the outrage cutting payments, I'd like to see at
least discussion coming back to different kinds of payment reform for the safety net.

CHAIR THOMPSON: All right. Let me again pause here for public comment before we wrap up our discussion.

### PUBLIC COMMENT

* [No response.]

CHAIR THOMPSON: Okay. So, Rob, what I hear the Commissioners suggest to you is, first, I think in terms of that recommendation around the process that we reconsider the use of the word "certify" and certainly lay out kind of general steps in the process from state submission, finalization with CMS, and then application of the information by CMS and the states in both submitting and certifying and allowing federal match. You will find a much better way of saying that than I just said.

I think it sounds like we could also use -- maybe take a look at the background on UPL at least to sort of start to explain why -- the importance of this, why it matters that states submit some of this data and look at this data and what part it plays in the overall system. It doesn't have to -- I don't think that has to be a lot more, but I think some of that would be helpful.
And I also think the conversation suggests to me that maybe we should explain a little bit more about this discrepancy between the payments and the demonstrations and possible explanations so that people can put that in context, that it may be a matter of the demonstrations not having all of the information, the payments may be fine. And, again, sort of putting it in the context of, you know, this is a set of management controls that the agency instituted in order to protect itself and the states against a situation where there would be a large-scale disallowance that would have to happen because when you get it wrong on UPL, you can get it way wrong. And then that flows down to, you know, all sorts of problems for the state and then the providers.

And so, you know, it's important to keep on top of this. It's important to keep using the information that's being provided. And, of course, if we ask states to submit information, we should only ask them to submit information that we're actually going to use. And so there's a basic idea there, too, as well. I think that if we can make those adjustments, we can finalize these particular ones and also recognize that we have some other
work that we're going to ask you to continue on in the context of the larger hospital payment environment and some of those conversations and then maybe in the context of understanding how the UPL gets calculated and whether that's something that could be further refined.

Okay. Why don't we go ahead and look for that to come back for a January votes? Thank you, Rob.

EXECUTIVE DIRECTOR SCHWARTZ: We're ahead.

CHAIR THOMPSON: We just went ahead of schedule, right. We will take a break. Do you think it's bad if we come back at 3:00 for managed care rules and get started a little early on that?

EXECUTIVE DIRECTOR SCHWARTZ: I think it's okay, but I wouldn't start now.

CHAIR THOMPSON: Yeah, okay. So we'll take a break. We'll start back up at 3 o'clock on the managed care rules.

* [Recess.]

CHAIR THOMPSON: Okay. Let's give it another 60 seconds and everyone can find their seats, finish their conversations, and we'll pick up a little bit early with the remainder of our afternoon agenda.
[Pause.]

CHAIR THOMPSON: Okay. Stacey is going to moderate the rest of the afternoon and go ahead and kick off our discussion.

VICE CHAIR LAMPKIN: Well, the long-awaited, long-anticipated update to the Medicaid managed care rules. Moira has a briefing for us, so we are excited to hear.

### REVIEW OF PROPOSED REVISIONS TO MEDICAID AND CHIP MANAGED CARE RULES

* MS. FORBES: Okay. Thanks, Stacey.

So, yes, today we'll discuss the proposed rule on revising the Medicaid and CHIP managed care rules. I'll give a little background. Since we've talked about managed care many times I'll keep that part brief. I'll go over the proposed changes and highlight a few areas that we've identified where you may wish to comment, although, of course, you know, the whole thing is open for comment, and we'll have the discussion.

So the federal rules for managed care oversight were updated in 2016, although some parts of them do not go into effect until 2017 and 2018. At the beginning of last year, CMS indicated that it would be considering revisions
to the rule and it also allowed states to delay
implementation of some parts of the rule that were supposed
to go into effect in 2017 and 2018.

On November 14th, CMS published the notice of
proposed rulemaking, or NPRM, to amend several parts of the
rule. Comments are due on January 14th. CMS said, in its
press release accompanying the NPRM, that it had worked
with NAMD, the National Association of Medicaid Directors,
I should say, and a group of state Medicaid directors to
create a framework for its review. Consistent with some of
the issues that it had raised in its letter in 2017, saying
they were looking at the rule, CMS said the changes are
intended to promote state flexibility, particularly in rate
setting, network adequacy, administrative requirements, to
strengthen accountability for CMS and the states, and to
maintain an enhanced program integrity, particularly
regarding cost shifting to the federal government.

It is not a comprehensive rewrite of the rule.

Most of the changes are in eight areas, which I'll go over
quickly on the next few slides -- I'll go over briefly on
the next few slides. I’ll try not to be too quick.

So there's a memo in your background materials
discussing the proposed rule. The appendix has a detailed summary of the proposed changes. I'm happy to answer any questions if I am too brief on any of this, but I'll highlight some of the main proposals here.

CMS has proposed changes to the rate-setting rules, which it says are intended to strike a balance between state flexibility and CMS responsibility to ensure actuarial soundness. It reversed a provision in the earlier rule and it will again allow states to use a rate range instead of a specific capitation rate for each rate cell, within certain parameters. It prohibits states from retroactively adding or modifying risk-sharing mechanisms to a contract late in a contract year or late in the state budget cycle. It provides additional guidance that states should follow when developing rates across different populations that may receive different federal match. And there are no changes to the medical loss provision. Although many people were anticipating that there may be changes to that, the proposed rule does not include any changes to the MLR and they don't ask for comment on that. The 2016 final rule added a new option for states to require MCOs to direct a portion of the capitation to
providers under delivery system or payment reform models -- they're called directed payments. States use this mechanism when transitioning to managed care so that they can continue to make supplemental payments that otherwise cannot be incorporated into managed care under actuarial soundness rules. The proposed regulations here clarify three types of allowable directed payments and it removes a requirement for CMS review of directed payments if they're using approved state plan rates, and it allows for multiyear approval of certain directed payments.

There are also changes to the pass-through payments policy. Directed payments that are not among the three allowable types described above are referred to as pass-through payments. In the 2016 rule, CMS clarified that while supplemental payments are permissible under fee-for-service rules and they created this directed payment option, comparable pass-through payments are not consistent with principles for actuarial soundness in managed care. So it required states to either gradually phase out pass-through payments within 10 years of the rule's effective date, or by 2027, or convert them into directed payments.

CMS now proposes to allow states to make new
pass-through payments for services and populations transitioning from fee-for-service to a managed care delivery system. The new pass-through payments cannot exceed the amount of supplemental payments that the state was previously making under fee-for-service, and the amounts must be phased out over three years.

There's a provision here that's not actually a change. It's a request for comment. The 2016 final rule provided states with additional guidance on when MCOs can pay for treatment in IMDs as an in-lieu-of service. CMS doesn't propose any changes but has requested public comment on additional data sources that it should consider to support the 15-day limit.

For network adequacy standards, CMS proposes to eliminate the current requirement that states establish time-and-distance standards for providers and instead will allow states to adopt a quantitative network adequacy standard. So that could be provider-to-enrollee ratios, percentage of providers accepting new patients, maximum appointment wait times, extended hours of operation, or so on. CMS also proposes to make corresponding changes to the requirements for managed long-term services and supports
programs. The proposed changes also clarify that states can define which provider types to include in access standards for specialist providers.

The 2016 rule required states to develop a Medicaid managed care quality rating system using either a CMS framework or a state-specific QRS that had comparable information to the CMS framework. CMS now proposes that states will be required to use a core set of measures, regardless of whether they're using the CMS or state-specific framework, but given that all states will now be using a common set of measures CMS also proposes that states won't be required to get CMS approval for developing their own state-specific QRS.

The proposed rule makes several small changes to beneficiary information requirements. These changes would provide states some more flexibility in language and format of information provided to enrollees, time in giving enrollees notices regarding provider termination, information included and timing for provider directory updates, and some things like that.

The proposed rule makes a number of small changes to the section on grievances and appeals. These provide
additional flexibility to states and may reduce enrollee confusion. For example, the proposed rule would eliminate the enrollee notice requirement for claims denied because they don't meet clean claim requirements.

Changes to the sections on CHIP, well, there's a lot of them. They appear to be primarily technical. They explicitly exclude certain provisions to the managed care rule, the Medicaid side, that don't apply to CHIP.

So there are four areas that staff have identified for comment. Really, there's three and then a potential answer to the question about IMD and in-lieu-of services. So I think I can go through all four of them, just so you can hear the whole thing, and then we can go back and I can answer questions as you discuss.

The first is directed payments. As I mentioned a few slides ago, directed payments have been allowed since 2016, where states can direct a portion of the capitation payment to providers to further state goals under delivery system or payment reform. The Commission has previously -- including in the last session -- raised concerns about supplemental payments and fee-for-service, how the lack of transparency makes it difficult to determine total payment
to individual providers, and how use of such payments affects achievement of policy objectives such as efficiency, quality, and access to necessary services.

Directed payments appear to account for a large proportion of hospital payments in some states. Last summer, we conducted a study of the development of hospital payment policies in five states and found that directed payments accounted for a large share of Medicaid payments to hospitals. In Michigan and Mississippi, in fiscal year 2016, they were more than one-quarter of Medicaid hospital spending and their use was growing.

CMS officials we spoke with also reported that they've approved 85 directed payment proposals in 28 different states. However, we only have information from our study because CMS doesn't routinely make any data on directed payments publicly available. We have asked them if directed payments will be included in the T-MSIS data at either the aggregate or the individual provider level, and CMS couldn't tell us if it would be or not.

It's also unclear if an upper payment limit applies to directed payments and how it would be enforced. As was just discussed, the UPL is intended to ensure that
payment to a class of providers doesn't exceed a reasonable estimate of what Medicare would have paid for the same service, but in managed care we can't tell if this limit is being applied.

Finally, the directed payments policy distinguishes these from pass-through payments by requiring that would be tied to some state goals for quality of care or outcomes under delivery system or provider payment reform models, and states are supposed to have an evaluation plan in place that measures the degree to which these arrangements advance these state goals or objectives. When we, again, got information from CMS, the most frequent goal actually cited by states is to encourage access, and when we talked to states last summer about how they're using these payments, none of them mentioned quality as a key consideration in the development of their directed payment policies. So there are questions about the extent to which the current requirements are being enforced.

So we have identified three areas for consideration by the Commission that we can come back to. You know, making provider level data publicly available, clarifying whether the upper payment limit applies for
directed payments and how it would be enforced, and
improving the reporting and monitoring of quality
strategies and evaluation plans for these payments.

The second area includes a lot of related issues.
The current rule requires states making pass-through
payments to phase them out by 2027. The proposed rule
would allow states transitioning to managed care, including
transitioning new populations or services to managed care,
to make new payments for three years. CMS says that the
rationale for extending pass-through exception to more
states is to support delivery system reform by recognizing
the challenges associated with transitioning supplemental
payments into payments based on the delivery of services or
value-based payment structures.

CMS notes that since the current rule was
finalized in 2016, it's heard from states that would like
to introduce or expand managed care, but would like to
continue to make supplemental payments.

The proposed change would also account for the
time it takes for states to transition to value-based
payment structures. Our interviews last summer with states
and stakeholders about the development of Medicaid hospital
payment policies certainly reflected some more similar ideas. Louisiana took about three years to convert some of its DSH payments into increased base payments to providers. I think Melanie had raised some concerns earlier about the challenges in changing payment structures.

So we've noted three areas for consideration. First, the Commission may want to comment on the proposal to extend the use of pass-through payments at all, whether this is -- right now there are existing payments that were grandfathered in and must be phased out, this would create a new option for this. And, in particular, whether the ability to make pass-through payments should be extended to states beyond those grandfathered in by the 2016 rule. This would include states that want to transition new services or populations to managed care.

If the Commission supports the extension of the pass-through option, MACPAC could make two suggestions to mitigate its concerns regarding supplemental payments. These are similar to the concerns with directed payments -- the challenge of determining total payment to individual providers and the effect of lump-sum payments on efforts to transition to value-based purchasing methods.
And then the third area for potential comment:

the 2016 rule requires states to implement time and
distance standards for specific provider types. Those went
into effect, as I said this morning, in July of 2018. We
talked about it this morning. The NPRM would require
states to adopt a quantitative standard of their choosing.
States could use different standards for different provider
types or different parts of the states. States would not
have to use a standard with a geographic or distance
component.

MACPAC's review of 14 current state network
standards found the states are using time and distance
standards, many with an urban or rural difference, with
exceptions clauses, as well as other quantitative standards
to account for differences within their states and
differences among provider types. Our review did not find
that any state could not meet the current requirements
within the flexibility allowed under existing rules.

Using at least one national standard -- although
states are allowed to develop their own benchmarks, but
they all have the same standard, which is time and distance
-- allows states and other stakeholders to compare network
adequacy measure across states. Moving to a mix of quantitative standards would make it harder to determine whether any state benchmark is appropriate because each state could be using not only its own benchmarks but its own mix of standards and measures.

And finally, this area of in-lieu-of payments for IMDs. The proposed rule again does not propose any changes to this provision. CMS noted that it could not identify new data sources other than those that they relied upon in 2016, which proposed a 15-day limit, and requested public comment on additional data sources that it should consider.

There are additional data sources, ones that CMS could consider when assessing this provision, and if MACPAC submits a comment letter it could include this information. For example, the 21st Century Cures Act requires HHS to study the effects of the 15-day in-lieu-of provision and issue a report at the end of next year, and that report must address a number of things, including the range of and average number of months and the length of stay during those months for beneficiaries receiving services in IMDs. A second data source would be data available through approved Section 1115 substance use disorder.
demonstrations. As of last month, 18 states had approved Section 1115 demos to cover SUD services in IMD settings. So we could certainly point those data sources out.

So before you discuss the potential areas for comment I do want to note that in the memo staff raised a couple of technical questions which we could include in a comment letter, if you choose to submit one, unless you object to them or want to change any of those technical issues. Comments on the proposed rule must be submitted by January 14th, which is prior to the next Commission meeting on January 24th. So this is your only opportunity to discuss your input on the proposed changes in public. Should the Commission decide to comment on any of the areas outlined above, or on other proposed areas of the rule, we can prepare a letter that reflects the discussion at this meeting. And you may also want to think about whether the changes or the concepts described in the NPRM suggest any other areas that you'd like staff to work on, going forward.

VICE CHAIR LAMPKIN: Thanks a lot, Moira. I have a couple of question and maybe a request for a little more elaboration on a couple of points. Looking back at
MACPAC's comments on the proposed version of the original rule, one of the things that we expressed a concern about was the administrative burden and the challenges that states might have in implementing some of the provisions of the proposed rule. And it sounds like at least CMS's intent with these proposed revisions now are to address administrative burden and state flexibility. That's a correct understanding?

MS. FORBES: That's what they've stated their goal is and they've pointed out, at several points in the proposal, where they believe that's what they're doing.

VICE CHAIR LAMPKIN: Yeah. And do we have a sense that the proposed revisions would, in fact, be meaningful in terms of reducing administrative burden for state Medicaid agencies?

MS. FORBES: It was -- I'm trying to think. I mean, we went through it. It was difficult to assess the change in burden. I mean, states are already doing a lot of things and these would make some things optional. And in some places there is less flexibility. I mean, there is a mix in the rule and in some places there is more flexibility and in some places there is less. So it's a
little hard to say what the net effect would be. It would probably depend on what choices a state makes, in terms of if they decide to go forward with certain options.

VICE CHAIR LAMPKIN: Okay. And the request for a little bit more elaboration or clarification. I think if we go back to Slide 6 you were talking about directed payments. And was this the slide where you talked about how many, preprint, CMS had approved with respect to different kinds of directed payments in a couple of states, Mississippi being one of them, I think? Can you remind us kind of what types of payments are falling under this directed payment category versus the pass-through, which is treated as a separate category and discussed differently?

MS. FORBES: Sure. No.

[Laughter.]

VICE CHAIR LAMPKIN: This is, I think, value-based purchasing.

MS. FORBES: It's value-based payments that can direct that you are making a value-based payment, that you're making an add-on payment, or that you're paying state -- that you're requiring them to pay state plan rates.
VICE CHAIR LAMPKIN: A specified maximum fee schedule --

MS. FORBES: Yes. That you're paying --

VICE CHAIR LAMPKIN: -- or a minimum fee schedule.

MS. FORBES: -- yeah, so that you're paying commercial or Medicare rates.

VICE CHAIR LAMPKIN: Yeah, or -- and I think there's a multi-payer delivery system reform --

MS. FORBES: If you're participating in it, yes.

VICE CHAIR LAMPKIN: -- that comes under this too. So I'm just trying -- I think it's helpful to name the kind of range of types of payments we're talking about as we think about the proposed -- like your question about should UPL apply to this. It's helpful to think what types of payments actually come under this category.

MS. FORBES: Mm-hmm.

CHAIR THOMPSON: Can I ask a UPL-related question while you're in that neighborhood?

VICE CHAIR LAMPKIN: Yeah.

CHAIR THOMPSON: I was slightly confused by the reference to UPL, because I think of UPL as that's fee-for-
service. Actuarial soundness, that's managed care. So is the question that we're asking whether payments that would have been made under the UPL, because they were fee-for-service, when converted into a directed payment under managed care, do they still need to be subject to the UPL? I mean, that seemed a little confusing to me, because it seems like the rule is setting an outside boundary for what can be brought over into managed care, and once it's brought into managed care it's subject to actuarial soundness. Correct?

MS. FORBES: Yes. Rob, did you have anything to add on that?

MR. NELB: [Speaking off microphone.]

CHAIR THOMPSON: Rob is very reluctant to come and talk more about the UPL.

MR. NELB: If you didn't get enough on UPL. So, yeah, you're right that actuarial soundness determines the limit on the overall capitation rate. A question, right, is if you did that directed payment option that's increasing rate to a provider, whether you could allow those providers to get paid more than what Medicare would have paid, or if there's any sort of limit on how high you
can go up for that particular provider classes, or whether
you just want to keep the limit with actuarial soundness as
it applies now, which is for the entire set of services
included under the managed care contract.

CHAIR THOMPSON: Right, although now UPL isn't
applied at the provider-specific level, but rather at --

MR. NELB: Correct, but for a class of providers.

CHAIR THOMPSON: Right. Okay.

VICE CHAIR LAMPKIN: So thank you for letting us
talk through the reminders, because I, too, was, like
Penny, I was a little puzzled by that -- some of those
suggested areas for comment around directed payments. You
know, do we know what CMS is seeing in the preprints, in
terms of the proportion of them that are specified fee
schedules versus some of the more creative things like
multi-payer delivery system reform or value-based
purchasing?

MS. FORBES: I can look back in the preamble. I
can't remember what they said. We can look back in the
preamble and see how much of that they might have
summarized.

My sense is that a lot -- part of the reason they
put the exception in for a state plan was because a lot of
states had done that.

VICE CHAIR LAMPKIN: Yeah. And I'm not trying to
put you on the spot. In the bits and pieces that I'm
seeing come through, it tends to be a fixed fee schedule
kind of dynamic, where it's very often the state plan fee
schedule that is at target. So, to me, that exemption
makes a lot of sense, but I didn't know if there was
perhaps more of the other types that make some of these
other comments perhaps more important. So thank you.

I'll just say one more thing and then definitely
want to solicit other's feedback. I was actually a little
surprised that perhaps a narrower scope of revisions than I
had imagined might be coming. A lot of what CMS has
proposed makes sense to me based on the way we've seen the
rule roll out. So I thought that was interesting.

Do others have comments or questions?

COMMISSIONER CERISE: I have a question, I
suppose. When you mention that the directed payments are
the primary reason a site was accessed, is there any
expectation that would go into what that is actually
addressing?
We talked earlier about gaps in access and how you really get at what the access issues are, and I'm wondering if we shouldn't ask for some more clarification about just general access, which is sort of the responsibility of the managed care organization to do with the actuarially based rates that you have, or you're talking about access to some pockets of specialty care, some other services. What else is getting lumped in there that you're trying to preserve or achieve? Do you know what I'm saying?

So, I mean, access is so general, you're already paying for access, although I know that you get like safety net providers that would say, well, you've got a lot more in that equation other than access for basic Medicaid services. You may be paying for access to specialists that are tough to get in Medicaid. You may be paying for other access to other services. You've got uninsured lumped in there too for providers that don't have the capacity to absorb that care, and so I'm just wondering what sort of specificity we expect when we talk about access as a reason for directed payments.

Then in terms of the accountability for those
payments, you mentioned examining the amounts, who they're being made to, and again, not to sound like a broken record, but it would be interesting to see that, again, net of IGT or provider taxes or things like that, so you can see what payments are actually going to support what providers.

There's great variation, and so if you just look at the amount, you may miss some of the action there. And so maybe even in addition to the amount, what's the source of the match, and then even things like the net incomes of those providers.

I'm struck by some years ago, there were reports of hospital systems that in Texas at least that were recording profits, and this was being shown up in their investor's report and related to the 1115 waiver program and supplemental payments. That's not the intent here, and so if you look at what are you actually getting for those directed payments, probing that, I think -- well, because you're already buying access.

VICE CHAIR LAMPKIN: Yeah. And so is some of that in the preprint? Because there has to be a linkage to the quality strategy for the directed payments.
MS. FORBES: So our research on the evaluation plans was from -- we didn't look at those. Someone else looked at them. We were looking at the literature on that, so we'd have to go back and try and dig some up.

COMMISSIONER CERISE: I just note you mentioned that none of the interviewees in your study mentioned quality as their key consideration, but access was the heavily mentioned thing. What special piece of access are we getting with more directed payments?

VICE CHAIR LAMPKIN: So are you suggesting, Fred, that there is a comment that we make to the proposed revisions related to that?

COMMISSIONER CERISE: I mean, I think it would be worth kind of probing. It's such a general category for the payment.

VICE CHAIR LAMPKIN: Okay. Do we expect that -- or, Moira, do we know whether the MCOs will have to report, through encounter data, the payments made for all these directed payments? The minimum fee schedule, maximum fee schedule type, I'm sure would come through encounter data, but some of the other kinds?

MS. FORBES: I don't know about encounter data.
We asked about the T-MSIS reporting and couldn't get an answer on that. I don't know what states are requiring for encounter data.

VICE CHAIR LAMPKIN: Okay.

MS. FORBES: We asked -- I mean, states have been making these already, so we asked to see if they were coming through already and couldn't get an answer on that.

VICE CHAIR LAMPKIN: Did you have something, Darin?

COMMISSIONER GORDON: So, first, I will say I was asked, my experience running a managed care program, on my thoughts on a variety of state-specific concerns with the managed care regs. I wasn't involved in any decision-making or the writing of the rule, but I'll just say that as a disclaimer.

On this particular issue -- and this is all just based on the documents in our binder, but the three areas that they clarified -- adopt a minimum and maximum fee schedule -- I remember having this discussion back when I was in Tennessee. It was like we were actually directing that our hospitals cannot be paid over 100 percent of Medicare, and it was prohibited under the other managed
care. I could not direct that.

In that same discussion was we took any excess in
a set of four and said you couldn't pay hospitals less than
this, so we put a range, but it was prohibited under their
prior managed care.

So, to Stacey's point, all that information, I
think we're blending supplemental payments and directed
payments here in this discussion.

So, in that one, yes, it's going to be picked up
in the rates that you're paying the specific providers.

Your provider uniform dollar of percentage
increase, payment rates, yes, that's picked up, and it's
specific to provider -- it's in your rate -- to be captured
in all your encounter data.

The one that gets a little bit more complicated
is value-based purchasing models, and the only reason I say
that is because some of those models, there's some things
that are done that aren't necessarily captured. The
payment out would be captured, but some of the activities
that are being done within value-based purchasing are not
being captured.

So separate the supplemental payments. Set those
aside. If you look at these three categories, I could see if every one of these would be capturing encounter.

And to your point on quality, I'm assuming that's tied to your value-based purchasing models. Your other ones -- when we would do increases, our legislature would require an increase per providers. That was a rate increase across providers that we would want to be able to dictate. So the plans just didn't get it built in their rate, and it didn't pass through. It was with the intent of keeping access in the delivery system.

So I think -- and, again, I'm speculating on things, but I know NAMD had written a long letter of here were their concerns, and I know these types of things were in that list. And that might be where some of the comments around access were articulated.

And, again, I can see in the first couple how that did apply in our case in Tennessee.

CHAIR THOMPSON: I'll just follow up. First of all, I agree with Darin. I think we need to be sure that as we're looking at the conversation on directed payments, we're being really clear about what the rule is proposing to change or not change with respect to that because I
think there is definitely aspects of that, that seem like
they're just avoiding a lot of interaction between the
state and federal government over things that are pro
forma.

I do think that the point about not -- certainly
not losing any transparency that we currently have and
continuing to promote transparency on directed payments and
supplement payments, wherever they're made, whether in
managed care or fee-for-service is consistent with ongoing
communications and prior recommendations of this Commission.
And that's something that I think we should just say as a
general matter.

On the additional opportunity to make pass-
through payments, it would be interesting to see if in the
public comment, we have any further observations on this.
But it's my experience that one of the things that has
happened before is that states have not wanted to go to
comprehensive managed care because they needed to retain a
fee-for-service payment structure in order to support
supplemental payments that they needed to make, and I think
that's what this is trying to address. And if I've got
that right, I think it's a good thing to try to address
that and to take away a bad incentive to maintain a fee-
for-service structure just because you have no other way of
ensuring that some of your safety net providers can be
continued to be supported or that you received the
financing that you're looking for to continue the program.

So I actually think if I've got it right about
the purpose of that provision, I think that's actually a
very good thing.

Those are payments that were already being made
in fee-for-service, so it's not like the program is
absorbing a new cost. It's simply allowing those costs to
get transferred over into that new system.

Under a phase-down, I do think that your point
about considering a phase-down in pieces is one worth
putting out there, but I'm not sure that we have enough
information to know whether or not that's the way that it
should happen or not.

So maybe I would -- I take it back. Maybe I
would say let's not go there unless we have a strong sense
that that's the way that it needs to kind of continue to
cut down. I'm not sure of that, especially in three years.

If you had a ten-year period or maybe a seven-year period,
you would want to see a systematic reduction over time, but
in three years, I think you could come up with different
ways of doing that, that would all be okay.

I think wherever we have information that we
should provide it.

I was interested in the earlier conversation
about adequacy about people's feelings about time and
distance. So I'm not sure what to suggest.

That we say there when you said, well, everybody
is using time and distance now, so everybody is meeting the
federal requirement now can be an argument that cuts both
ways, which is, well, then you don't need a federal
regulation to say it because everybody is just doing it.
That's just standard practice. Or are they doing it
because -- in other words, there's a little bit of a -- if
everyone is doing it, then is it important to keep that in
the rules?

I heard a lot of Commissioners talk about the
limits of a time and distance standard for really giving
you insight into where you stand with access, so maybe
that's something other Commissioners could chime in on.

COMMISSIONER GORDON: I agree. It does beg the
question if everyone is doing it, does it prohibit it, and
I think as we had the discussion earlier, it's more complex
than that. That that standard, in essence, is
insufficient, and they're not saying you can't do it.
States can use that, but they're saying you should have
some quantitative standard.

EXECUTIVE DIRECTOR SCHWARTZ: I think in the
earlier conversation, though, we said all states were doing
it -- of the states you reviewed, states were doing
multiple other things as well. So the existence of the
time and distance standard didn't prevent them from doing
other things.
I don't know, Moira -- that they're doing the
time and distance standard because that's what's required
to do.

MS. FORBES: In the 2016 rule, in the preamble,
CMS noted that part of the reason it had settled on time
and distance was because most states were doing time and
distance then.

CHAIR THOMPSON: That's a little bit of a chicken
and the egg kind of situation.

COMMISSIONER GORDON: I will say I don't know if
it -- and I'm just speculating here as to whether or not that had something to do with -- if that's all I say is the standard, is that endorsing that as being a sufficient standard versus the fact that really the reality is I think most people who have gotten into it acknowledge that it's not.

And I don't know if we all agree what all that should be included in doing that well, but I would say that isn't -- that bar is a fairly low bar.

CHAIR THOMPSON: Can I ask a question? Do those standards get subject to any kind of public notice?

The other thing in this is you get built in -- we talked earlier again about what's posted and what's in contract and what's in RFP and what's in state regulation and those kinds of things, and so I just wonder if there's something for us to say about we know it's complex, and we know there's a lot do different considerations maybe for different populations, maybe for different kinds of services, and maybe what we should be saying is the public needs to be involved in that conversation.

MS. FORBES: The current rule says that the state quality strategy needs to include the network standards,
and the state quality strategy has to include a public review. It has to be --include that. I'm not exactly sure how the public is supposed to be involved, but there's a draft and a final and the CMS review.

CHAIR THOMPSON: Maybe that's just something that we could note that we think is -- in providing this kind of additional flexibility, that we note the importance that we would attach to that being part of -- an important part of the conversation that's taking place with stakeholders in devising the strategies.

VICE CHAIR LAMPKIN: Anything else on network adequacy?

[No response.]

VICE CHAIR LAMPKIN: Any comments on the IMD changes or request for other data sources? We can flip to that next slide.

I think Moira had called out we could make a comment about a couple of other data sources, the 1115, the SUD waivers. Do people feel that these comments are important for us to make? Any opinions?

[No response.]

VICE CHAIR LAMPKIN: So maybe we could take a
break from our discussion and hear any public comment or feedback on these proposed revisions and get that perspective in front of the Commission. Do we have any members of the public who would like to comment?

### PUBLIC COMMENT

* [No response.]

VICE CHAIR LAMPKIN: Okay. So hearing none, it's not -- I'm not sure that I have a sense of the Commission about whether we feel strongly about providing a comment letter. I've heard some pieces like, well, we could stress the importance of continued transparency. That's been important to us before. We could stress the importance of public input into the network adequacy standards. Do we have enough reaction to these proposed changes that we want to submit a comment letter and what are the major feedback that we would provide?

CHAIR THOMPSON: I think we should provide a letter. I think there's various pieces of information or observations, but I do think that, in general, I don't see -- and this is myself, and I'm not hearing from the other Commissioners -- a lot of points of serious concern, objection, and so that we ought to be generally expressing
the view that the changes are -- I think, Stacey, you
describe them as kind of within a reasonable range of
decisions that you could land on and hear their -- you
know, I think there's things for us to continue to make
sure that we draw the agency's attention to, but not with
respect to any particular, in my mind, suggestions about
changes, other than perhaps to reaffirm the desire to see
some of this provider-specific data continue to be a point
of contention.

VICE CHAIR LAMPKIN: And then, Moira, you said
there's some technical comments that would be included in
the comment letter.

MS. FORBES: That was around whether or not DSH
would be included and some of the definitions. There was
like one small thing in there.

CHAIR THOMPSON: Martha's turn.

VICE CHAIR LAMPKIN: Oh, yeah. Sorry, Martha.

COMMISSIONER CARTER: So I'm having a semantic
problem here. So CMS is asking for additional data sources
to support their 15-day limit, not whether the 15-day limit
is appropriate or not? That's what I thought I read.

Okay. Is there anything -- and you think that we
could provide some additional data sources?

MS. FORBES: Yes. I mean, those are additional data sources.

COMMISSIONER CARTER: If we chose to do a comment, that we would include.

MS. FORBES: Mm-hmm.

COMMISSIONER CARTER: That seems reasonable.

VICE CHAIR LAMPKIN: Okay. Thanks, everybody.

Next up, another proposed rule.

Kirstin and Kristal.

### REVIEW OF PROPOSED RULE AFFECTING INTEGRATED CARE FOR DUALLY ELIGIBLE BENEFICIARIES

* MS. VARDAMAN: Good afternoon, Commissioners.

We're going to end today with an overview of another proposed rule.

On November 1st, CMS published a proposed rule with policy and technical changes related to Medicare Advantage and Part D. Our presentation today will focus on proposed changes regarding Medicare Advantage dual-eligible special needs plans, or D-SNPs. These proposals would implement provisions of the Bipartisan Budget Act of 2018, which was enacted in February of this year. The Bipartisan
Budget Act established new requirements that D-SNPs must meet by plan year 2021. I will discuss the ways in which CMS proposes to implement new requirements regarding the integration of Medicare and Medicaid benefits, and then Kirstin will discuss the unification of grievance and appeals procedures.

As we reviewed the proposed rule, we found it to be straightforward in its implementation of the BBA requirements. The proposed new minimum integration standards, which we will discuss shortly, seem to be in agreement with the Commission's interest in using integrated care to improve beneficiaries' care experiences. Similarly, the procedures proposed to unify grievance and appeals processes seem reasonable given the Commission's past work in this area.

Given our assessment of the rule, we do not have any suggestions for areas for comments; however, in the course of your discussion, if the Commission identifies areas where it would like to provide comments, we can certainly draft a comment letter. The deadline to submit comments on this proposed rule is the end of this year.

BBA 2018 mandated that D-SNPs meet one or more of
three requirements regarding the integration of Medicare and Medicaid benefits. I'll walk through each of them in the next few slides.

First, the BBA said that a D-SNP must, in addition to meeting existing requirements of contracting with the State Medicaid agency, meet an additional minimum set of requirements for integration established by the Secretary based on input from stakeholders. CMS proposes to implement this provision by requiring that D-SNPs notify the Medicaid agency or a designee of hospital and skilled nursing facility admissions for at least one group of high-risk, full-benefit dually eligible beneficiaries as determined by the state Medicaid agency.

This requirement would apply to D-SNPs that are not fully integrated dual-eligible special needs plans, or FIDE-SNPs, or that do not provide long-term services and supports or behavioral health services under capitated arrangements. Such D-SNPs are covered under other options that we'll discuss soon.

CMS’s rationale for this proposal is that these notifications could be used to improve care transitions. Improved communication could promote better transitions of
care into the setting of a beneficiary's choice. For example, if states are promptly notified of hospital or skilled nursing facility admissions, they could connect beneficiaries with opportunities to receive home and community-based services, or HCBS, following discharge.

Under this proposal, states would select the subpopulations requiring D-SNP attention. For example, a state might define a high-risk population as all individuals using HCBS. Alternatively, states could use claims or encounter data to target certain high-risk individuals such as those with a history of hospital readmissions or who are high users of certain services.

The proposed rule acknowledges that states are not all similarly positioned and provides flexibility in how states implement this requirement. States would establish their own notification procedures and protocols, time frames, and method of notification. CMS notes that states may choose to expand requirements as processes and infrastructure mature over time.

Under the second BBA option, D-SNPs can either meet most of the requirements of FIDE-SNPs or enter into a capitated contract with the state Medicaid agency to
provide long-term services and supports, or LTSS, behavioral health services, or both. To implement this provision, CMS proposes to define a new category of D-SNPs, referred to as highly integrated dual-eligible special needs plans, or HIDE-SNPs.

Under the third BBA option, if a parent organization operates both a D-SNP and a Medicaid managed care organization, or MCO, that provides LTSS or behavioral health services, then the parent organization must assume clinical and financial responsibility for benefits provided to beneficiaries enrolled in both products. The proposed rule interprets this such that a D-SNP that is either a FIDE-SNP or a HIDE-SNP with exclusively aligned enrollment would satisfy this requirement. Exclusively aligned enrollment, as CMS proposes to define in this rule, refers to cases in which states restrict D-SNP membership to individuals receiving Medicaid benefits from the D-SNP or Medicaid plan operated by the same MCO, parent entity, or other entity controlled by the D-SNP's parent entity.

The BBA specified that for 2021 through 2025 the Secretary could impose a sanction for D-SNPs that do not meet the new integration requirements, which is what CMS
proposes in this rule. CMS proposes to prevent a D-SNP from enrolling new members if it does not meet the new integration requirements. The agency interprets this enrollment sanction as a lesser penalty than a contract or plan termination while D-SNPs transition to the new requirements. While sanctioned D-SNPs could not enroll new members, such a sanction would not disrupt care for previously enrolled beneficiaries.

And now I will turn it over to Kirstin.

* MS. BLOM: Thank you, Kristal. Good afternoon, Commissioners. Now we'll turn to appeals and grievances, which we've talked about before.

So BBA requires that the Secretary establish a unified process for enrollees in D-SNPs to the extent that that's feasible. That's important because CMS decided that it's most feasible for a subset of D-SNPs that have this exclusive alignment that Kristal talked about. Just to reiterate, that's where one plan is responsible for both Medicare and Medicaid coverage and the parent organization is the same across the D-SNP and the MCO. CMS set it up this way because they believe that this is the way that it's most feasible to manage the process under one entity.
CMS estimates that this will affect about 37 plans, 37 D-SNPs in eight states, which is about 7 percent of enrollees.

Because procedures are only going to be unified for a subset of D-SNPs under this proposed rule, that does mean that requirements for other D-SNPs won't change, and if the rule was to become final, there would now be different requirements for this subset versus all other D-SNPs.

CMS is also proposing to align the processes only at the health plan level, and this is due to challenges that occur in going beyond that level, which I'll talk about in a little bit. Aligning at this first level, the health plan level, establishes a single entity, the health plan, which beneficiaries can use to process their appeal. This is consistent with what most states have done under the Financial Alignment Initiative. Only one state in the duals demos went beyond the health plan level, and that was New York, which created a fully integrated process.

Some of the key elements of the proposed unified process for this subset of D-SNPs that are particularly relevant to Medicaid include requiring that D-SNPs assist
their enrollees with their Medicaid coverage issues,
including helping them file appeals, also maintaining state
flexibility, which is consistent with current law, where
standards might be set in regulation but then states have
the option to provide additional beneficiary protections.
For example, time frames are often set in regulation at a
certain minimum. For example, 30 days is the requirement
for resolving an appeal, but states choose to make that a
shorter time frame to provide additional protection for the
beneficiary such as in Ohio where it is limited to 15 days.

CMS also adopted Medicaid's continuation of
benefits provision. This is a provision that's unique to
Medicaid, it does not occur in Medicare. Under the
proposed rule, that means that beneficiaries in these
subsets of D-SNPs would be able to continue receiving
Medicare and Medicaid benefits while their appeal is
pending.

Interestingly, CMS does estimate a fairly minimal
impact on Medicare spending as a result of this provision
because in their estimation most Medicare benefits are not
continuing. Either they have already been provided, such
as emergency service benefits, or they're subject to
immediate review rights under Medicare, whereas, for example, with inpatient hospital services a beneficiary has the right to demand -- to request an immediate review of a denial of those benefits.

These key elements also reflect some of CMS’s guiding principles as they've described them in the proposed rule, which include setting up a process that's most protective for the beneficiary and maintaining state flexibility.

Although CMS did not propose going any further than the health plan level, the agency did include a thoughtful discussion of alignment beyond the health plan level, and here are a few things to consider from that discussion.

CMS took into account New York's experience. I mentioned them earlier as the only state in the duals demos to have a fully integrated process. They've set that up, and people seem very happy with it there, but I think we should remember that New York's enrollment levels are a little bit -- they're on the lower end of the enrollment spectrum in the demos, so that has been applied on a fairly small scale, and we are not -- we don't know how that would
be replicated nationally.

Another consideration is around differing jurisdictions. Under current law, Medicare and Medicaid both allow judicial review if an appeal makes it all the way to the end of the process. In Medicare, that review obviously is a federal judicial review, but in Medicaid it's a state court responsibility. So reconciling differences of jurisdiction like that would probably require one program or the other to delegate authority to either a state or a federal entity in a fully unified process.

Another challenge is around state flexibility and the potential constraints on it as a result of the additional rulemaking that would probably be necessary for a fully unified process. CMS believes that a fully integrated process should be optional for states rather than a national requirement. And states obviously administer their programs very differently. That's something that we as the federal government have encouraged them to do. But in a situation where CMS is creating a fully unified process, there would probably be specific rulemaking required in that arrangement that would then
constrain the kinds of options that states have come to know and take advantage of.

So with that, we're happy to take any questions you have. We felt this was, as Kristal said at the outset, a fairly reasonable approach to the rule, so we're happy to hear your thoughts.

VICE CHAIR LAMPKIN: Thank you, Kirstin and Kristal. You can go first, Melanie.

COMMISSIONER BELLA: Thank you both very much. I have a comment on each piece of it.

I guess on the grievances and appeals, I understand why CMS would start where it starts. I don't understand why some more states aren't in the list of exclusively enrolled, like Pennsylvania or Arizona, but whatever, that's an aside. I would encourage, though, they could -- when I was at CMS and we did that in New York, it was with the intent to learn from New York and then expand that to the other demonstration states, too. So in addition to doing it in these states, they could actually extend it to the other demonstrations in the Financial Alignment program as well, and I think that might be worth mentioning.
CHAIR THOMPSON: So you're saying that we ought to encourage them administratively to continue to get more people into the world of trying to build that fully integrated system rather than through a rulemaking.

COMMISSIONER BELLA: I'm just saying -- so in all of the other demonstration states, they didn't go as far as New York, and so they could take all the other demonstration states to New York in addition to doing it in these other exclusive enrollment states that they're talking about. Does that make sense?

One of the big sticking points was Part D. Part D was a really big one to figure out, and that was the hardest part for Medicare to sort of delegate to this function in New York. But even though they're small numbers -- and you were kind in how you described the size of the FIDA demo -- I do think that there's enough that went into it that there's a lot to learn from how we even got the Medicare folks to be comfortable with this, as well as the advocates. And so I think there's probably a lot to learn, even if there's not a lot of experience of people actually going through the system.

On the other points, there's been a little bit of
grumbling from states about the reporting piece for the
states that will have to go through the hospital reporting
ing. I don't know that it's worth us commenting on. I
guess my comment would be I would like to see us, even if
it's making a small statement, make a statement to the
agency indicating that we support this move toward
alignment and, you know, we keep raising the bar. But I
want to hit again on this thing about look-alikes. More
information is coming out about the look-alikes. It looks
like in 2019 there will be 40 states with look-alikes, and
if the look-alikes -- again, just to remind folks, to be a
dual-eligible special needs plan, you have to have an
agreement with the state Medicaid agency. If you can't get
that agreement -- and some states are saying, "I'm going to
try to line up my Medicaid managed care plan with my
Medicare D-SNP," to get a -- you have to win a Medicaid
bid, and the state says you also have to be a Medicare D-
SNP, and they line that up. And they won't give MIPPA
agreements outside of that because they want people to go
into an aligned product.

The plans that can't get in, that's one of the
reasons they've become this look-alike. They can't get a
D-SNP agreement from the state, so they go in as a plain
vanilla Medicare Advantage plan. They don't have to comply
with any of the model of care rules. They market to duals,
and the brokers are aggressive about it. And so I just
think it's -- the agency is asking for people to let the
agency know that this is an issue that people are concerned
about with regard to the possibility of the undermined
integration, and I think this would be an opportunity, even
if it's just a couple sentences, to say as we continue to
support the move toward integration, please be wary of this
explosive growth -- we don't have to use "explosive" -- in
look-alikes. We understand you don't feel like you have
any authority there, but we encourage you to keep an eye on
it because it's going to undermine all these things that
you've nicely set out in this rule. So I would put a plug
in for that.

CHAIR THOMPSON: I agree with that.

VICE CHAIR LAMPKIN: Toby.

COMMISSIONER DOUGLAS: I would just add to what
Melanie said. I don't think it -- I think it's important
just to add to that point on the look-alikes, is that to
the extent we strengthen the requirements of D-SNP, it's
going to push more plans to go in that direction, saying,
okay, I don't want to have to do this, I'll just go around
it with a look-alike. So they can't -- I fully support
these changes, but it has to be done in concert with
preventing those plans from moving around it.

VICE CHAIR LAMPKIN: Okay. Brian.

COMMISSIONER BURWELL: So I agree with everything
Melanie said. On the first provisions, in terms of how
this is operationalized, it looks to me like there has to —
— there's a state decision. This isn't just -- the D-SNPs
have to do one of these three things in order to maintain
their status as a D-SNP, correct? But the decision about
which of the three is required seems to be more of a state
decision that then would get incorporated into the MIPPA
agreement, like reporting to the state about hospital or
nursing home admission. You know, so to me it's a two-
sided or a two-pronged policy decision around the
implementation of this rule. Is that your perception as
well?

COMMISSIONER BELLA: Yeah, I mean, the states
have already sort of picked their delivery system vehicle,
and so I think, yeah, they are going to have variations on
this. And this is why also, though, it is legitimately a
problem for D-SNPs that want to operate in states that kind
of won't do any of these things.

COMMISSIONER BURWELL: Right.

COMMISSIONER BELLA: So that's just an issue, I
think, that needs to get addressed outside of this. But,
yeah, I mean, the state is already deciding, though, do I
want to capitate, fully capitate, do I not? If not, then
we'll offer the opportunity to do the data sharing. But
it's --

COMMISSIONER BURWELL: Yeah, my question is more
-- so the D-SNP has to do one of these three things. Is
that correct?

COMMISSIONER BELLA: Right.

COMMISSIONER BURWELL: So before it can make that
decision, it has to go to the state and go, Which one do
you pick?

COMMISSIONER BELLA: Yeah, I mean, the D-SNPs
already have -- most of them already have -- they either
have a contract for the capitated contract with the
behavioral health and long-term care, or they don't, or
they're in a state that -- what?
COMMISSIONER GORDON: Or [off microphone].

COMMISSIONER BELLA: Yeah, but you can't just have a MIPPA anymore.

COMMISSIONER GORDON: I'm saying there's a process. Every D-SNP is going through and interacting with the state, and the state is setting out its expectations in a MIPPA agreement. Now, some actually have more robust expectations than others, but I'm just saying there's always that interaction at that point if the state has, to your point, policy goals or objectives they can insert that in the MIPPA agreement.

COMMISSIONER BURWELL: Okay.

COMMISSIONER GORDON: In other words, they are already having to talk to the state, basically.

COMMISSIONER BURWELL: Well, it would also be the document by which the D-SNP would go straight to CMS that it has met this requirement is that here's our MIPPA agreement and we are doing this under our MIPAA agreement currently.

VICE CHAIR LAMPKIN: Okay. Penny.

CHAIR THOMPSON: So I agree as well with everything that's been said. I think we should write a
letter that is supportive of the rules and the approach they've taken. One thing I've just not heard mentioned, I was just really glad to see them continue the protections that are afforded generally through Medicaid, as they think about unifying. And I think calling that out, that's always been a bit of rub, and I'm just really glad about where they've landed with respect to those issues.

COMMISSIONER BELLA: I'll just add onto that. I think we should specifically call out Aid Paid Pending, even though they minimize that.

CHAIR THOMPSON: That's right.

COMMISSIONER BELLA: I think we should highlight that --

CHAIR THOMPSON: That's a big deal.

COMMISSIONER BELLA: -- as a very positive thing that that you wouldn't get in just regular Medicare today.

VICE CHAIR LAMPKIN: Other comments? Do we have public comments on this rule, on this proposed rule?

PUBLIC COMMENT

MS. DOBSON: I can't resist. I'm sorry.

Hi. Camille Dobson. I'm Deputy Executive Director at NASUAD. We represent the aging and disability
directors who deliver LTSS. We are in the middle of reviewing the reg ourselves and sending it out to the states, and we found a number of places where the NPRM asked for comment and feedback from the states. So a couple of things.

We are also very glad, I think, to see Aid Paid Pending. It's been a problem for our states. They're also worried, Melanie, about lookalikes coming in and undermining especially those states that have made a real effort in their MLTSS program to do exclusive alignment. And what we are hearing is that they would like Medicare to be more active in putting some guardrails around. So I think that's probably what we will say in our comments. I don't know. I always wait to -- somebody always says something that I don't expect when we send it out for review to our members.

And then the other thing that I didn't pick up, and I want to make sure maybe if Kirstin found this. I thought we read a piece that does not allow the state or the SNP to go -- to recover services once they've been delivered Aid Paid Pending. At least that's how we read it, that regardless of whether Medicaid allows, like has a
rule that allows the state to go back, or the plan to
recover services that are Paid Pending. We saw that
changed. And I don't know if I read that correctly but
that might be -- it's a good thing for beneficiaries.
Obviously, it's not a thing that I think, from a
beneficiary protection position, is very good, for people
to have to worry about having their benefits clawed back,
if it turns out when they get through the process that it
goes against them.

And so I would just double-check to make sure
that I've read it the right way, because it's very
confusing. That whole unified appeal section was a little
hard to get through. It was very dense.

And I think that was it. And again, I think
we're glad that it's still -- the state is the one that
still decides sort of the scope of the arrangement that
they have. I think we think that MMCO did a very gentle
approach to this and deferred a lot to the states. You
know, our fee-for-service states are really struggling with
how to manage integration when they don't, either can't or
won't, for policy reasons, capitate services.

And so they're trying -- I think some of them
would actually like to go beyond, which is funny, not only that you said you're hearing some grumble from the states. Our fee-for-service states actually would like to have -- I think have started to use their MIPPA contracts more broadly to drive some integration with their fee-for-service LTSS program. Not all, but I think a number of them are looking for better ways to get hold of the duals. It's all we talk about now at our meetings is, you know, how to get control of the duals when you can't deal with Medicare.

That's it. Thank you.

COMMISSIONER BURWELL: So I guess I have a question. So if you're a D-SNP in a fee-for-service state that doesn't do MLTSS, the only way to meet this requirement is the first option. Is that correct?

MS. VARDAMAN: Yes.

COMMISSIONER BURWELL: Yes. I'm also trying to think through. I mean, states do switch their MLTSS contractors sometimes, which will affect the aligned D-SNP, but I guess if you lose it on the Medicaid side you lose the D-SNP too.

COMMISSIONER BELLA: They released policy about a
year ago that allows, for a time, when the plan change
happened there's an enrollment mechanism to allow to change
that member into the new plan so that they still have that
alignment. It happened in Arizona. So they do have --
they are looking toward having a mechanism to pull the
beneficiary with that for continuity. So it's not perfect.

And the grumbling, Camille, I totally agree with
you. The grumbling was about do I have the systems and the
IT in place to do the reporting.

MS. DOTSON: Yeah.

COMMISSIONER BELLA: It wasn't absolutely they
want more tools. I totally agree.

MS. DOTSON: Yeah. To me that's a problem.

COMMISSIONER BELLA: Yeah.

MS. BLOM: Can I ask one question? Commissioner
Bella, you mentioned that the intent was to have more
states take up the -- or do what FIDA did, basically. Do
you have a sense of why that hasn't occurred? I mean, Part
D was kept outside of New York's process anyway, right, so
--

COMMISSIONER BELLA: [Speaking off microphone.]

MS. BLOM: It was brought in? Okay.
COMMISSIONER BELLA: I believe it was brought in while I was still there. I can double-check that. And my guess is it just fell so lower on the priority list. That the thing was -- the thought was, at that time, to learn from New York and then see if we wanted to expand that to the other demonstration states, and perhaps just other things have taken priority. I don't know.

VICE CHAIR LAMPKIN: Any other comments or questions?

[No response.]

VICE CHAIR LAMPKIN: All right. It's a wrap.

CHAIR THOMPSON: Great. Terrific day, as always, Commissioners. Thank you to the public for your contribution. We will see you tomorrow.

* [Whereupon, at 4:12 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Friday, December 14, 2018.]
PUBLIC MEETING

Ronald Reagan Building and International Trade Center
The Horizon Ballroom
1300 Pennsylvania Avenue, NW
Washington, D.C. 20004

Friday, December 14, 2018
9:02 a.m.

COMMISSIONERS PRESENT:

PENNY THOMPSON, MPA, Chair
STACEY LAMPKIN, FSA, MAAA, MPA, Vice Chair
BRIAN BURWELL
MARTHA CARTER, DHSc, MBA, APRN, CNM
FRED CERISE, MD, MPH
KISHA DAVIS, MD, MPH
TOBY DOUGLAS, MPP, MPH
LEANNA GEORGE
DARIN GORDON
CHRISTOPHER GORTON, MD, MHSA
SHELDON RETCHIN, MD, MSPH
WILLIAM SCANLON, PhD
PETER SZILAGYI, MD, MPH
ALAN WEIL, JD, MPP
KATHY WENO, DDS, JD

ANNE L. SCHWARTZ, PhD, Executive Director
AGENDA PAGE

**Session 8:** Panel: Medicaid in Puerto Rico:

Challenges and Opportunities

Kacey Buderi, Senior Analyst

Panelists:

Angela Ávila Marrero, Executive Director, ASES

Orlando González-Rivera, President, MMM Healthcare

Gloria del C. Amador Fernández, Chief Executive Officer, Salud Integral en la Montaña, Inc.

Public Comment

Recess

**Session 9:** Further Discussion of Medicaid in Puerto Rico

Kacey Buderi, Senior Analyst

**Session 10:** Highlights from the 2018 Edition of
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Session 11: Measuring Performance and Return on Investment for Program Integrity Strategies

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CHAIR THOMPSON: All right. We are going to give the 30-second warning here, and then we'll kick off.

[Pause.]

CHAIR THOMPSON: Okay. We're happy to start off this morning with a discussion on Puerto Rico, and we have some great panelists to help us understand the situation on the ground there.

I think, as everybody knows, we've been having these conversations around the Puerto Rico situation. We have issued some issue briefs associated with that. We have a request for some data and some information in the FY 2019 Labor, Health and Human Services, and Education funding bill that we want to respond to. This conversation this morning will help us move along towards meeting that request.

As is our practice, we will have opportunity to hear from panelists. We will have an opportunity to ask them some questions. We'll then take a break and have a conversation among the Commissioners following that.

Kacey, you're going to kick us off here this
morning with both introductions to our guests, and also I think you're going to start us off reminding the Commissioners about where we stand on some prior questions and data requests that we've been discussing up until now.

### PANEL: MEDICAID IN PUERTO RICO: CHALLENGES AND OPPORTUNITIES

* MS. BUDERI: Sure. So today, we are continuing our discussion of Medicaid in Puerto Rico with an expert panel, and we have been asked by Congress to evaluate and assess viable options for ensuring long-term, sustainable access to care for Medicaid beneficiaries in Puerto Rico.

At our last meeting, I provided an overview of how the program works and pointed to some of the challenges the program and the larger health care system are facing, which include ongoing hurricane recovery efforts, access and infrastructure challenges, as well as a capped Medicaid allotment and the upcoming expiration of supplemental federal Medicaid funding, sometimes referred to as the "Medicaid fiscal cliff," coming up as soon as September 2019.

Additionally, Puerto Rico's Medicaid program is subject to spending reduction targets required over the
next five years by the Financial Oversight and Management Board for Puerto Rico and is currently undergoing some reforms to help achieve those targets.

So to help provide the Commission with a deeper and more nuanced understanding of these issues, we have convened an expert panel who can offer their insight on the situation on the ground, the reforms and opportunities and challenges in the near and longer term.

And so the panelists are Angela Avila, executive director of the Puerto Rico Health Insurance Administration, or ASES, which is the agency in Puerto Rico responsible for many things, including overseeing and contracting with Medicaid managed care organizations. And Ms. Avila has been with ASES since 1997, working in diverse areas, including finance, statistical analysis, contract negotiation, and ICD-10 implementation. And she has occupied positions ranging from finance director, analyst administrator, and executive subdirector, so she has intricate knowledge of the Medicaid program.

We also have Orlando Gonzalez, president of MMM, a Medicaid managed care company operating in Puerto Rico. He has been president of MMM since 2008, and his
professional trajectory includes positions such as administrator of the Puerto Rico Socioeconomic Development Administration and executive director of ASES.

And then, lastly, we have Gloria Amador, CEO of Salud Integral en la Montaña, which is a federally qualified health center offering primary and preventive health services throughout its network of community health center locations in several different municipalities. Ms. Amador has over 20 years of administrative and leadership experience in the health sector, including 11 years as the auxiliary director of Special Programs for the San Juan Department of Health, where she supervised 18 local, state, and federally funded programs. And she's also held a number of different board and committee memberships.

And so to get us started, I will turn it over to Angela who can discuss ASES's view.

*MRS. AVILA: Well, good morning, everybody. For me, it's an honor to be here and have the opportunity to share some information about Puerto Rico and our government health system in the island. It is really just like a dream come true to be able to show what we are confronting in Puerto Rico in terms of the needs in our health care
I have been working, as Kacey mentioned, for more than 20 years in the government of Puerto Rico and specifically in the Puerto Rico Health Insurance Administration, so I have had the opportunity to see how the managed care system has been developed in the island. So this has been a 20-year experience of dealing with managed care for more than 1.3 million participants in the Medicaid program. So it is a great opportunity to share with you what we are confronting right now, and as in the invite, they asked me to address some specific topics, and that's what I'm going to try to do in just like ten minutes, eight to ten minutes.

So I would like to start just saying that Puerto Rico has a 100-percent managed care model for the Medicaid program, and as I mentioned, we have 1.3 million, almost 1.3 million participants in that program. It is managed care. We used to have a regionalized system, and that means that we used to have presence of managed care organizations in eight different regions. It was one managed care per region, and right now, we are doing some
major changes in terms of improving the health system,
improving the managed care, improving the competence, and
just going to go for quality outcomes. We want to pay for
quality outcomes instead of paying for a per member per
month premium without any other considerations.

So we are experimenting a huge change in Puerto Rico, and that was the main subject that this Commission was interested in -- what we are doing, what are our challenges right now -- and I just want to cover on a high level those topics in specific.

As I mentioned, we are just doing a huge change in the managed care model in Puerto Rico. We are just bringing the coverage throughout the whole island in order to have participation of the managed care organizations throughout the island. Everybody needs to compete right now just to have beneficiaries or members in their organizations, and that is a huge change because now the participants have the right to select the managed care plan of their preference, the network of their preference, and we are giving the opportunity also to providers to choose which administrator deals better with their interests.

Nevertheless, we can do a lot of changes in the
managed care area, but our biggest challenge right now is
the sustainability of the system. And we have been
confronting an underfunded system for more than 20 years in
Puerto Rico, and no matter which changes we can include or
implement, if we don't have the right funding, we would not
accomplish that sustainability and continuity of the
program.

We are confronting in the near period right now,
short term -- we are confronting challenges. We don't have
providers that are willing to accept any other reductions
in their rates. Our providers -- a doctor in Puerto Rico
earns less than a hair stylist. A doctor for a visit gets
like $10, and when you go and do your hair, you spend more
than $50. And that's the disparity we are confronting.

When we compare what the Medicaid programs
throughout the states and other territories are receiving
for the program, it is a difference between $400, $500 per
member per month to almost $200 is what we have per member
per month to cover the entire system right now. So it is
so difficult to have doctors that have been educated in a
way that meets the state standards -- we have our good
doctors that go through all the boards in the States, and
they know how to speak both languages. And we don't have resources to keep them in the island.

So, lately, since before the hurricanes, we're starting to see an exodus of the professionals in the island and mainly in the clinical areas, and our health professionals are leaving the island. So it is very difficult, even though if we have some grants to cope with the needs of paying some reasonable amounts to these professionals to be able to keep them in the island.

Also, one of the other biggest challenges that we have is the beneficiaries, people that find other -- with medical needs in the islands are also leaving and getting to the States to find those services and have better quality of services there.

So we have a mixture of some, two very important causes that we need to keep on tracking and see how can we look for mechanisms and collaborations and better funding for our health program in Puerto Rico.

And the main one that we are confronting in a short term is the cliff, the famous Medicaid cliff in Puerto Rico. We were experiencing this cliff before the hurricanes in 2017 because of the ACA funds, the period of
ACA funds for Puerto Rico. So right now, we have the release of the BBA. We are counting for first time historically 100 percent parity in Puerto Rico for the Medicaid program.

It took two hurricanes and an emergency of huge impact in the island to be able to receive 100 percent parity in the Medicaid program, and it has been almost a miracle, I will say, because that way we could do the implementation of the new model. We comply with the requirement of the fiscal board because if we don't have any warranties, we cannot proceed with any negotiations if the fiscal board doesn't approve it. So if we don't have the appropriations certified from the Congress and HHS, we cannot do anything in the island in terms of new negotiations and implementation of anything related to the health care.

So thanks to the BBA, we have been able to accomplish a new model, a new negotiation. Right now, we have five main companies that are willing and doing the management of our Medicaid program in terms of services, and what happened is that that effort is only for 18 months and is going to end in September 2019. So it's going to be
-- again, we need to face another cliff, another situation uncertainty. We don't have a recovery funding that would meet our actual expenditure in the island.

And just to give you an idea of how the disparity is, when we compare with other states, we are like in position 12 of the states that have -- states or territories that have the most population under the Medicaid program, and we are receiving funding in comparison with the 48th state or territory that receives the lowest amount of funding for their programs. That's the type of disparity that we are talking about.

So my message, we have a lot of information. We have the projections. We have all the details that you may need, and anything else that you may ask, we are more than willing to share with you and have the opportunity to bring the message.

I brought here expertise that like Milliman are our actuaries in Puerto Rico, like Mercer are our consultant for pharma affairs. We have all the things here. If you have any questions, any doubts, we are more than pleased to answer whatever information you may need to help us just do a better job and send a message for Puerto
We want in Puerto Rico to stay there. We love our island, and we would like our people to go because they want to, not because they need to. There is a lot of potential in the island. We have a great economy and an opportunity of economy. We have like -- we used to be like 4 million Puerto Ricans. Right now, we are almost 3.4, and people are leaving. And we need urgently to look for permanent solutions to avoid that, look for permanent solutions to Puerto Rico being an asset for the States.

We are very proud of being American citizens. That's for sure, and that's why I'm here, just for that.

So thank you so much for the opportunity.

* MR. GONZALEZ: Good morning. My name is Orlando Gonzalez. I am the president of MMM, as Kacey has said. I have been 12 years with the company on the insurance side, but before that, I was the executive director of the largest hospital in Puerto Rico, Auxilio Mutuo. Before that, I used to occupy the chair that Angie holds today, so I used to be the executive director of ASES. So that means that even though I'm representing an insurance company, in reality, probably my perspective would be a little bit
broader than that because I have been able -- I have the opportunity to be in multiple sides of the industry.

And I put together a couple of slides just to make reference to, hopefully be brief, so you guys can really spend the time making the questions. But, as Angie said, this is a managed care, 100 percent managed care for more than 20 years on the island, $2.7 billion that is invested every year to provide access to cover covering 1.3 million people with over 6,000 unique providers. It is a block program versus an entitlement, and that's very important. There's going to be some data that I'm going to be sharing with you as to the challenges with that.

Interestingly, through the program, more than 50 million prescriptions are provided every year, investing more than $600 million there.

There's a particular item. That's why I want to highlight this because you will see later on the impact that the prescription drugs has on the overall program, and then it creates about 16,000 or so employees, employment on the island, so it's a very huge program.

As Ms. Avila said, 47 percent of the Puerto Rico population participates in Medicaid. That's unprecedented.
No other jurisdiction of the state has such a high level of participation, so that's particularly the importance of the program, but it also speaks as to the socioeconomics of the island, which is the main issue. I mean, we have people -- if you see there a profile of the participants within the program, 50 percent of them make less than $10,000 a year. Seventy-one percent of them are unemployed. Seventy-six percent of them are below federal poverty level. Sixty-six percent of them have lower than a high school diploma. Fifty-four percent of them are single, claim to be single, and 71 percent of them also get nutrition assistance program. So, as you can see, it's a very poor and uneducated population.

You see the data on reimbursement. This is, I believe, the key of the issue. Look at the reimbursements per member per year that are invested on Medicaid, the spending that is invested in Medicaid in each of the states, and then you see the right side, a green bar and a red bar. Those are Puerto Rico. The green one, it's what's currently being invested in the program.

Right now, it's at 100 percent FMAP because of the temporary funding that was assigned at the beginning of
last year after the hurricane. If we were to turn that to what is mandated by law, the 55 percent FMAP, that number would go down to basically $1,100. It doesn't matter how you look at it. Actually, even with 100 percent FMAP and with the additional funding that Puerto Rico is getting, it's 50 percent of the lowest state. So you're having the highest penetration, probably the poor people in the whole country, getting half of the lowest state to get services.

What is the issue with that? Of course, there's going to be multiple challenges when you have that situation because when you go and see the health conditions, Puerto Rico is not healthier than other people in the states. Actually, it's sicker. If you'll see, for example, diabetes, you'll see the green line. Puerto Rico scored highest than any other country in terms of prevalence of diabetes, but we have the less funds. You see the blue bar. So we have highest condition, less funding.

If you move to look at the right side and you see the cardiovascular diseases, again, scoring very high, very low funding.

If you move to the next one and you see
hypertension, similar situation. We're among the top on prevalence, lower funding.

The same is true for high cholesterol.

So you see we have a population that is very sick with a lot of chronic conditions, but we have less funding. You can argue there is a correlation that they have developed those conditions because of the historical lack of funding that Puerto Rico has received. Nevertheless, if we don't get the funding, this is not going to get better. It's going to get worse, and that's concerning. And not only that, it's concerning for the program as a whole because you will see later on what are the impacts and the effects of this disparity.

Moving into the next one and trying to sort of put some data as to what are the issues that create this lack of disparity, let's take pharmacy as an example. Pharmacy, it's the pricing of the pharmacy that the insurance company has to pay. The pharmacies and the PBMs are based on AWP, similar to the States, and actually, the pharma companies cannot lower the price because if they lower the price, they have to honor that price to the other states. So what they do is they keep the price consistent
But if you saw that we have 50 percent less funding than in the States, but you got to pay the same price on drugs, what happens? What happens is that the other providers are going to get much, much less dollars because the premium is fixed. It's a block. It's a block program. So what happens is that it puts undue pressure on other providers, and you'll see doctors getting much, much less dollars, and you'll see hospitals getting much, much less dollars because it's the only way that the system can operate under those circumstances.

Take a look at that chart in the middle, and you will see how much dollars out of the total pharmacy dollars are invested in the Medicaid in the nation. It's about 10.7 percent, not even 11 percent. If you see Puerto Rico, look at '15. It was about 19 percent, and then in '17, because if the increase in drug prices, it went up to 25 percent. That's the proportion of the dollars that are invested in pharmacy, and you see in two years, it went up more than 5 percent.

What is the impact of that? That put pressure, and then doctors and other sectors are getting less
dollars. In our case, that second bullet is MMM data specifically. That impact alone represented more than $5 million less going into the pockets of the doctors. If you extrapolate that to the program, we're talking about over $20 million, just one year over $20 million less going to the doctors, into the doctors' pockets.

What happened then? When you see the compensation of physicians and providers and other health care professionals in Puerto Rico versus the States, we are in a very disadvantaged position. Let me tell you, -- there's these people that -- many of these doctors train in the States. They train in the States, or they train in segregated organizations in Puerto Rico, and they get, in some instances, 50 percent of what other professionals get.

What happens is that Puerto Rico's -- because Florida, Texas, New York, other jurisdictions are going to the island to hire doctors, offering twice the salary to get them out of the island, creating a crisis, a crisis for us, and actually putting Puerto Rico in a much disadvantaged position.

You see that chart in the middle, it's estimated that in the last five years, we have lost more than 1,100
doctors, and if you see that chart -- I'm sorry for this slide. It's a little bit crowded, but I thought it was important to put this data point. But if you see that chart with the blue and the green bars, look at the mix in terms of age of the Puerto Rico physicians. Look at the young doctors, 35 years or younger, Puerto Rico has 4 percent versus the States with 24. And as you move to the right, we have a more concentration of older doctors, so that basically confirms young doctors are leaving the island. Older doctors are staying because they already have their practices for 20, 25 years. It's hard for them to close those practices and leave, but this is going to be an issue for the island in the upcoming years because as these guys start retiring, Puerto Rico is going to lack doctors to take care of the patients, unless something is done to fix this issue and we can start providing a better compensation to our doctors.

And this is not just impacting the doctors. Look at what happened to the members. This is data from 2016 that shows that out of the people that Puerto Rico has lost, a large number of the people is Medicaid people. Most of them go to Florida, and this is the most bizarre
situation because they go to Florida, and then the federal
and the state government ends up paying three times what
they pay in Puerto Rico.

So by increasing a little bit of Puerto Rico and
creating stability in Puerto Rico, you will save as a
program, as an overall, significant amount of dollars
because every member that goes to Florida, it is costing
the system three times more than what it costs to keep them
and treat them in Puerto Rico.

So Ms. Avila said it very clear. The uncertainty
really is -- it's really destroying the system.

Right now we're facing that in the -- next click
-- in the third quarter of '19. Actually, negotiations
with the insurance companies will take place on Q3 of '19.
So the issue and the situation for us, as insurance
companies, is we're going to be negotiating something
without the certainty of what's going to happen, whether
the funds are going to be available or not.

And that creates a lot of impact, also, on the
program as a whole but on providers, and, you know, it's
going to continue to contribute to the shortage that we
have in certain specialties. We have a shortage of
endocrinologists, rheumatologists, neurologists, psychiatrists. And particularly psychiatrists, I want to emphasize that one because one of the main issues that we're facing after the hurricane is a significant increase of suicides and a significant increase of depression and anxiety. The statistics show that suicides have gone up more than 18 percent on the annum.

So it's a fragile infrastructure after the hurricane. You know the island was very, very a long period of time without power. Hospitals were severely impacted. There are some hospitals that are operating maybe at 20 percent of what they used to operate. Of course, they're in the process of, you know, reconstructing.

Take, for example, the island of Vieques, which is a municipality. It's an island on the east part of Puerto Rico. It's still running on generators, and for dialysis those patients were being brought to the island three times per week until about a month ago, that temporary facility was set up so that they can take the dialysis, you know, at the municipality. The doctors were very impacted as a result of the
hurricane because they didn't have the infrastructure to
deal with this, so that put a lot of pressure on the
hospitals, as the doctors were not available to take care
of the patients on an ambulatory level.

As I said, the concerns regarding the mental
health and the depression and anxiety, and, you know, there
is some statistics that, you know, shows that at least
almost 3,000 people, you know, died as a result of, you
know, not getting the treatment, the care that they needed
after the hurricane.

So to conclude, recommendations, I think it's
important for Congress to act and to put reasonable
financing. I don't think anybody here will be asking for
treatment similar to any states. I don't think that's the
proposal. I think a reasonable cap pretty much
consistent with what we're getting after the emergency.
And, you know, my recommendation will be, or our
recommendation will be to keep the 100 percent FMAP at
least for two more years, until the island recovers, and
then have an FMAP equivalent to 83 percent, which is sort
of what Puerto Rico will be getting if we were treated with
parity.
Remember, the situation with the block is twofold. One is amount. The second one is FMAP. So if we get a reasonable amount and a reasonable FMAP. Even with that, Puerto Rico will still be 50 percent lower than the lowest state. I'm not asking for same amount of any other state. I'm saying even with that, Puerto Rico still will be in a disadvantaged position, but at least with more certainty to invest on the program to put more dollars to providers.

I think important is also to promote quality. If you look into the Medicare side there is a five-star program that is very robust to promote quality, and the plans have done a good job in Puerto Rico. Actually, the three largest players in Puerto Rico are four-and-a-half stars, with 95 percent of the people in Medicare Advantage in Puerto Rico are covered by four-and-a-half-star plans. So I think Puerto Rico takes these topics very seriously.

So I think something similar, special funding for that will be interesting and something that can be defined between the states and the Federal Government as part of the state plan. And also, if you look at the Medicaid side, certain services are not provided on the island. We
don't have the providers because there is no funding, no infrastructure. So perhaps demonstration projects, I mean, funding for demonstration projects can be also put in place to promote things like PACE, for example, that are precise to address fewer people with community base in coordinate with Medicaid and Medicare. So those are, you know, just to name an example of things that can be done.

So thank you very much and I am open later on for any questions.

* MS. AMADOR: Good morning, everybody. Thank you for the invitation to be part of this panel of the MACPAC. The previous panelists have presented and I also had the opportunity to be on the government and the private hospital industry in Puerto Rico. So today I'm presenting, as a CEO of one of the biggest FQHCs in the central region of Puerto Rico. You have the presentation as referenced.

The first slide is only a profile of our organization. We have nine sites, four emergency rooms, and two mobile units located in seven municipalities. We also run home care and hospice certified Medicaid programs. We have over 540 employees. Last year we reported to the Federal Government 39,002 patients that we served.
budget, federal funding is around $16 million, and we run an operation of over $75 million. It's just one small cluster of the providers but you can see how big is our impact in the central region of Puerto Rico, with just a lot of shortage of doctors and services in that area. Seventy-eight percent of our population is Medicaid patients, so we depend on the managed care system to provide services to this population.

We run in Medically Underserved Areas and HPSA, Health Professional Shortage Areas, designated by HRSA. All medical services are offered to all, regardless of the persons have little to pay, and this year alone -- we close on December 31st -- we are serving over 48,000 unique patients. That's because we have four emergency rooms that's an entrance to our primary care setting, when we receive new patients from other MCOs. So we introduce them to the setting so they can stay with us.

And also the population we serve are the more vulnerable populations, including the underserved, the economically distressed populations, the uninsured, the migrant seasonal farm workers, individuals and families experiencing homelessness, and those living in public
housing projects, as well as HIV/AIDS patients who are very costly to treat.

This is just a reference from Medicaid in Puerto Rico. We started managed care models in 1993, and that's the way we have been providing services, health services, through the distinct managed care organizations, through risk-based contracts. The government contracts with the MCOs and they contract with the providers, with the IPAs or the FQHCs, through a fee per member per month capitated payment, so we can provide all the services to the population.

We also receive a supplemental wraparound payment from the commonwealth that is to cover the difference among our costs, our service costs, and to what we receive as capitated payment.

The State Children's Health Insurance Program, you also know all about the law that covers that, but specifically in Puerto Rico the CHIP funding is based on the number of low-income children receiving it in each state, but in Puerto Rico it's burdened by two discriminatory caps. One is the funding allotment not based on the number of children and also that the federal
matching rate limited to territorial cap of 55 percent instead of the maximum of 83 percent if we were treated as a real state.

Also, the FQHCs are required to provide care to those CHIP beneficiaries as if they were located in any of the 50 states, although the unequal reimbursement rates that we receive.

This is the statistics of the 20 FQHC organizations in Puerto Rico. We report, in the UDS -- that's a uniform statistic report that we submit to HRSA, to the federal health department. We serve 240,000 patients, representing 20 percent of all the Medicaid patients in Puerto Rico. There's over 32 -- in our organization, 32,500 Medicaid patients in my organization alone, and the patients on Medicaid that we expect next year is 1.2 million patients in Puerto Rico. So 2 out of 10 patients in Medicaid are receiving services at any of our FQHCs in Puerto Rico. So you can have the perspective of how important is our settings in Puerto Rico.

Also, part of the unequal treatment in the funding to Puerto Rico was the funding for the Medicare program. It's subject to territory cap. We have the FMAP
in a minimum of 50 to 83, but we are set in 55 percent. So if we will receive the 83 that we are supposed to be receiving, due to the poverty levels that Puerto Rico, the island have, so we will be receiving that sum of the 83 percent, representing billions of dollars additionally to Puerto Rico.

What about ACA? Angie talked a little earlier. ACA made three principal changes to the federal contribution to Puerto Rico Medicaid program that permanently raised the FMAP to 55 percent, provided $5.4 billion, above the statutory cap to cover July 1st, 2011 to September 2019, and also for the subsidies for the Marketplace coverage, Puerto Rico receive additional $925 million. But the unfair treatment to Medicaid with temporary funding is still capped, and the FMAP is significantly below the 83 percent that it would be if its rate was based on a non-capped formula. Puerto Rico would have fallen into a cliff, but Hurricane Maria make a difference on the funding we received last year. As Angie also told, Maria -- and Orlando told you a little bit about what happened with Maria. Maria was the deadliest hurricane to hit the United
States in the last 100 years. We were without energy, without water, without diesel, without ATMs, without banks, without port, without airports, so everything was shut, and especially the infrastructure on the health system was demolished. Many of the hospitals were closed. Less than 15 percent of the hospitals were running on the first week of the hurricane, after the hurricane. And the federally qualified health centers were the only ones responding in the communities to provide services to the patients. So we were an ally to the government to provide services in the most difficult times in the island.

Thanks to the Congress we received funding, in the Bipartisan Budget Act in 2018, that is until September 30, 2019, and that's where the most concern is. What's going to happen when we get to September 30, 2019?

Also, in Puerto Rico there is restrictions on the eligibility requirements due to the cap on the funding, that Puerto Rico has to establish a Local Poverty Level. So a lot of patients are getting out of the managed care system, so it represents that those patients now are being converted to uninsured and most of those patients are coming to our health centers to receive the services
because nobody else is giving them the services if they cannot pay.

So the use of the Local Poverty Level instead of the Federal Poverty Level results in lower Medicaid enrollment that directly affects the FQHCs in fewer Medicare patients assigned, which decreases our capitation and our wraparound revenues, meaning more uninsured patients.

So what's going to happen after September 30? So Puerto Rico fully expects that after that we will revert to the statutory cap of $357 million. The possible consequences once Puerto Rico reaches the new Medicaid cliff is that the commonwealth probably will no longer be able to comply with the wraparound payment to FQHCs. The Medicaid enrollment will decrease in beneficiaries, equivalently reducing FQHC's assigned Medicaid populations and capitation, as I already said, and will translate in decreasing revenue and in excess of millions of dollars a year.

FQHCs will be forced to treat a proportional increase of uninsured patients without corresponding state reimbursement. So even if we receive wraparounds and we
receive capitation and we receive federal funding, we won't be able to subsidize those uninsured patients because money have a certain -- designated to certain operational costs and to services, so we probably won't have the capacity to serve all the population.

So some of the barriers that Hurricane Maria and the unequal treatment, and with this I'm closing my presentation. Patients suffer significant challenges in accessing physician specialties and difficulties in receiving referrals. During the hurricane, a lot of medical offices were shut down, so it was very difficult for them to continue with their treatment and to get their medications. So a lot of patients were coming to the health centers, to the federally qualified health center to continue their treatment, even if they were patients that belonged to other providers in the area.

Many Medicaid offices are closed, causing that patients cannot recertify on time, and currently the recertification appointments are for February of 2019, after the enrollment period, which caused a delay for beneficiaries to remain active in the program. Now there was a waiver that allowed patients for a whole year to come
to continue their enrollment in the Medicaid program, but now that they are coming back to recertification there's so many people getting into the process that the appointments are for next year. So it's going to be very difficult for them to get services between November and January this year, because they won't be able to recertify.

Also, there is new requirements and established criteria disqualifying many beneficiaries, such as those of the CHIP programs where the mother of a child, if left without the coverage, due to new restrictions requirements, although FQHC accept them and assume the economic burden, but if the mother is out of the system the child is going to be out of the system too.

The Puerto Rico Health System has become one subsidized by the federally qualified health centers, due to all the population have been left without the health coverage, and the FQHCs have continued to offer those health services to them.

Another barrier is that Hurricane Maria caused great damage to the system and caused, for several months, a barrier to access to health care services on the island. Drug donations resulted in savings for insurers who did not
pay for the services provided through the waivers offered, rejecting claims. And today we are still working with insurance companies to get paid for all the services we provide to patients who do not belong to our organization.

The cap on Medicaid program drives us to a gap in funds, and also a gap in care. The New Single Region Model established by the health government has increased the costs of managing the program because the five insurers do not operate the same way. So now the federally qualified health centers or the providers need to have additional operating staff to cover all the regulations that these new five contracts give us to maintain the compliance with all of them.

FQHCs are required by federal law to provide its medical services to all patients, regardless of their ability to pay. An unexpected increase of uninsured patients in Puerto Rico will translate in more patients into our system, and we don't have the total federal funding to cover them.

And the consequences of this unequal treatment is that we will face a Medicaid funding crisis, leaving more than a million U.S. citizens without coverage. The
significance of inadequate funding are rolled along the weakest link of the chain, that is the providers and the patients. The Commonwealth of Puerto Rico is burdened with a second-rate health system, and also unequal treatment directly targets the most vulnerable populations in Puerto Rico: the elders, the poorer, and the unprivileged children.

And the recommendations is that there should be a change in the formula used when allocating the funds in the health area that allow citizens to access better services that result in better quality of life. Only with the Congress' intervention, Puerto Rico will have the necessary funds for its Medicaid and CHIP programs to continue operating after October 1st, 2019. Allow services not currently being provided, such as long-term care, and also give flexibility to use funding for programs that heed social determinants of health. That's a very important and significant area that we have to treat.

And to finish, follow up implementation on the Health Innovation Plan that was created in consensus with all the stakeholders and approved by CMS to create a bridge
of the current situation to value-based models. I have the
document here. I can leave it as a reference if you don't
have it. But there is a lot of information that was
gathered through a lot of stakeholders to look for new ways
to implement innovative models to decrease the cost of
services and to increase the quality of services.

    Thank you very much.

CHAIR THOMPSON: Thank you all. First of all, that was very informative, and as you were going through a
number of your slides and remarks, I think it really
responded to some earlier conversation that we had in this
Commission about things that we were interested in learning
more about, so you've really put us on the road to
understanding the situation much better.

    I want to open it up to the Commissioners. We'll
have about 25 minutes' worth of time here to ask some
questions of our panelists. So let me start off with
Sheldon and then go to Martha, then Peter.

COMMISSIONER RETCHIN: Well, first of all, thank
you for your participation in the panel discussion. For
me, it continues to be a heart-wrenching situation, and
here's where I'm at, and maybe you could help me out. We
could talk about it as well from others, maybe Kacey could provide -- the gap. So if the cap was changed to 83 percent of an FMAP, how big is that number? And then in your view, if -- I mean, one of the things that is bothering me about the whole discussion isn't that a decision might be made to change the FMAP and lift the cap for funding Medicaid. I'm assuming that in traditional congressional action it may happen in August of 2019.

In the meantime, the uncertainty appears to be draining both the medical workforce -- and I guess my question -- to get back to my question -- is whether you think changing the FMAP sooner than later will prevent the out-migration of citizens of the island, and particularly into Florida. It's a complicated question, but, I mean, without -- what do you think a sooner action than later would really do?

MRS. AVILA: Excellent question. We were just figuring that number, the specific number that would be if we approach the 83 percent. We were talking -- and if I'm mistaken, José, please verify. We were talking about $600 million per year in differences in funding. And if we...get to that point -- I'm sorry. Sometimes we are
looking for the specific words. What we are going to allow for is just to be able to bring better fee schedules for our health care professionals, and only that movement and that initiative will bring a lot of growing concern for the health system. So for us we need to identify additional funding to pay better doctors and health professionals.

And in order to establish those fee schedules as guidelines our positions, we will need the additional funding. Right now, with the BBA, the $4.8 million, we were able to keep what we have up to October 31st. We asked the managed care organizations not to reduce any penny to the doctors and professionals, and that was the agreement. If we keep this budget, we can at least stop decreasing fee schedules because that was imposed by the fiscal board, and we can keep the system until the health care -- the federal health care system can give us some guidelines and us to be able to insert that in those new exchanges.

On the other hand, when I started coming to the Congress and see what was happening, everybody told me you can keep on going with 100 percent managed care models, but everybody has found out they are very costly, and we need to look for other alternatives. And that's why we got into
the new system because we were looking for some immediate
cost containment initiative, and that's why in the middle
of the hurricane and just after the hurricane, we started
working with the new model because we cannot have the
luxury of having the BBA and do nothing, because it's not
going to change. So that's why we open for competence. We
are dealing with high-cost, high-need populations to be
able to treat the specific condition and the patient and a
fixed premium amount that will take care of whatever is
available, or you can do with that money. So we have put
some short-term initiative that will stable the cost
increase in terms of the model, and that's the way that we
have been working so far.

So the answer is yes, the money will allow us to
have at least a stable system until doctors and
professionals see that we are doing something that is bring
some hopes and opportunities to remain in the island.

MR. GONZALEZ: If I may add, there is no doubt
that, you know, time is of the essence. I think it's sort
of where you're heading. The sooner the better. We
understand there are processes. I mean, this is probably
things that can't happen overnight, but there is no doubt
that the sooner the better. The island is definitely in need of positive news. It is being bombarded by, you know, the debt crisis, then the hurricane, the system, you know, the next cliff. And when you have such an environment and then you have companies that are targeting the island because you get professionals, bilinguals, some of them even train in the states, used to work under very rough circumstances, and when they go to the states and they have to work with these new very fancy facilities, servicing, very organized, you know, they're stars because they're used to working with very tough situations.

So it's very attractive, and companies and hospitals and health care organizations in the states have realized that, and every month we have a couple of fairs of different companies going to the island looking for nurses, looking for pharmacists, looking for physicians, because they have identified, you know, low-hanging fruit of people that are willing to listen because of the uncertainty that they are living every day.

CHAIR THOMPSON: So I have Martha, Peter, Kisha, Stacey.

COMMISSIONER CARTER: Thank you for your
presentation. I wanted to highlight an issue that I heard and a question. So the FQHCs take care of 1.2 million Puerto Ricans, which is 20 percent of your Medicaid population. So I'm trying to wrap my head around, you know, you have a mandated rate, a PPS rate, which the state must pay or the commonwealth must pay, and without that funding, what's going to happen? You know, the FQHCs can't survive, obviously. So, I mean, it really puts that whole health center system, the community health center system in grave jeopardy, and puts the state in a Catch-22 of noncompliance. You're not getting the money, but you're mandated to pay it. Correct?

MS. AMADOR: Yeah. Let me clarify. The 1.2 million people are the beneficiaries of Medicaid -- the federally qualified health centers serve only 20 percent of them. Last year it was around 240,000 patients that we served. But, yes, we do receive PPS, but it comes from the same block grant from Medicaid. So if they don't receive the whole amount, one, they're going to diminish the amount of patients that they receive, so we're also going to receive less PPS rates. And, also, they will be uninsured, so they will stay in the system, but we will get -- we will
have to get different funding sources to keep continuing
the services to service that population.

MRS. AVILA: And if I may add, also whatever we
are obligated or we cannot comply with also will bring us
to noncompliance with PROMESA and the fiscal board that is
added upon our fiscal realities right now.

Moreover, if we allow the system to collapse --
because this is not a -- when I started just coming here to
talk about the Medicaid cliff, we were talking about if we
confront the cliff, we will need to get out of prescription
drugs or we will need to get rid of the dental coverage
because it's an optional coverage, or 600,000 members will
going out of the health care system. That was at that time
that we were not confronting an exodus of the amounts that
we are looking at on the island after the hurricane. We
were confronting exodus during the past five years, but not
in the amounts of hundreds of thousands of lives.

My impression and with my experience of more than
20 years in the health care system, in the managed care
area, I have seen a managed care model that can show the
states how to do better managed care because with such lack
of funding, we have been knowing managed care for more than
two decades, we saw it getting into a chaos just pulling our doctors to the edge, pulling our hospitals, even our managed care organizations that everybody said that they have a lot of money, that is not the reality in the island. I have been looking at financial statements, utilization trends, and I have been meeting with other managed care administrators through the states. And when we talk about the mechanisms that we have in place in our system, like how we manage our PDL in terms of drugs, you know, that the Government of Puerto Rico, we've seen the managed care is the one who control all the drug administration by PBM and PPA contracted by the government, not by the managed care organizations. And we are the ones who deal with the rebates and the pharmaceuticals. It's not an option that we haven't tried in Puerto Rico in terms of managed care, and right now I go to other Medicaid places and people ask me, "How are you doing this? How are you doing these operations? How do you deal with the managed care organizations?" And we can show to do better managed care businesses. But even with all those initiatives, it's not any other alternative right now. I cannot get back to a managed care organization and say you need to do whatever
you're doing with less money. That's the way we were used
to doing business in Puerto Rico. This is the budget.
This is what we can certify. Who is willing to work with
this type of environment? And people were doing it
because, as I told you, they like to be on the island. The
island has a way of enchanting the people, I will say. But
it has become a time that it's not possible. You cannot
pay a PCP, a generalist, a pediatrician $12 per visit.
That is not good medicine. You cannot have a surgeon
moving -- how you say? -- the tray and the patients to the
hospital to make the surgery. They don't have the staffing
to support them. Then you add, because of that, the
malpractices and the cost of those insurance. And the
people in Puerto Rico have the same costs or more to be
educated. So they have their loans. They have all these --
- all the complexities that a health system carries, and it
is not a matter of keep cutting things. If we need to cut,
we would need to say, you know what? No more health care
system as we know it. The government will need to do
drastic changes. We will not be able even to comply with
the federal government, even with nobody. We will need to
go to do medicine of the Third World. That's probably
sometimes you go and see things that you will get amazed.
But that is the reality of what we are facing right now, and it's a matter of we used to have 18 months, we only have like I would say less than a year to fix whatever mechanism we can consider and give some continuance to the program.

CHAIR THOMPSON: All right. Let's jump over to Peter. We still have Kisha and Stacey who are waiting to ask some questions.

COMMISSIONER SZILAGYI: Yeah, thanks for your presentation. This is really disheartening and shocking, every time I hear information about what's going on. To me it's just a demonstration of if you have a fundamental gap between the funds and the needs, the best MCOs, the best providers, the best people just can't meet those needs.

Could you give a little bit more of a face for the 1.2 million people? How many of these are children? And how many of these are pregnant women? And out of the 900,000 who may lose health insurance, how many are children and pregnant women?

MRS. AVILA: If you will allow me, I have Mr. José Carlo. He's from Milliman. He's one of our assistant
actuaries, and he has those specific figures. I know
about, you know, average, but if he can answer, he will
give you a better -- a specific amount.

MR. CARLO: So the CHIP program, which is an
expanded CHIP program on top of Medicaid, covers around
86,000 children. In regular Medicaid there's around
340,000 children ages 0 to 20. And pregnant women, there's
about -- from our calculations, about 1,100 births on the
island each month in the Medicaid program, so extrapolate
that through a year. And I missed your other question
after pregnant women.

COMMISSIONER SZILAGYI: So is the estimate that
out of the 900,000 who may lose health insurance, that it's
pretty much the same demographics?

MR. CARLO: Yes. So I will mention that the
Puerto Rico Medicaid program also covers a population of
about 160,000 people in the commonwealth or state
population, which is above the Medicaid enrollment
requirements. So that would be the first population to be,
I guess, removed because it's not a federally required
population. And so that population has similar
demographics, although it has less children, because most
are covered through CHIP if they were not in the
commonwealth.

COMMISSIONER SZILAGYI: Okay. Thank you. And do
you know the percent of residents who are uninsured and
actually should be on Medicaid or CHIP?

MR. CARLO: I think that was in one of the
presentations, but it's a low percent.

MR. GONZALEZ: Yeah, Puerto Rico has very low
uninsured population. It's average 6 percent. Out of
those, how many should be? Hard to --

COMMISSIONER SZILAGYI: That's helpful.

CHAIR THOMPSON: So that's the total uninsured.

MR. GONZALEZ: Uninsured.

CHAIR THOMPSON: Not the eligible but not
enrolled.

MR. GONZALEZ: Total uninsured on Puerto Rico.

COMMISSIONER SZILAGYI: Okay. And the last
question: The 600 doctors or providers who are leaving,
can you give a sense for what -- how many are there in
Puerto Rico? What is the percentage?

MR. GONZALEZ: The percentage, out of those that
stayed?
COMMISSIONER SZILAGYI: Providers who are leaving. You know, just sort of a general sense.

MR. GONZALEZ: Yeah, just so you get a sense, Puerto Rico six years ago used to have about 11,000 registered doctors. Today it is about 9,000.

PARTICIPANT: Or less.

MR. GONZALEZ: Or less. We have lost about 2,000 providers. Actually, if you go to the Board of Medicine, most of them are canceling licenses in Puerto Rico just because they're moving out looking for better opportunities, and the issue is the youngest one. And then they train; they in the past used to come back to the island. They're not coming back. They're training in other places in the states, and they're staying there.

MS. AMADOR: And there's another issue that the numbers are not -- they're estimated, because there's a lot of doctors who are leaving the island but are keeping the license in Puerto Rico open, active. So if they want to come back, they can have it. So we don't really know, and the Colegio de Médicos, the association that covers all the doctors in Puerto Rico, they don't even know really the numbers of how many doctors are really giving services in
Puerto Rico because that's the issue with the active licensing and moving to the states. So it's around 7,000, but it's just an estimate.

COMMISSIONER DAVIS: Thank you again for coming all this way. It was just a really eye-opening presentation, and I think for a lot of us, we knew it was bad, but didn't know it was that bad. So I really appreciate you being here.

I wanted to ask, just following up a little bit more on Peter's question, specifically about primary care and network adequacy since so many folks are leaving. One, what is that starting to look like in terms of wait times for patients, accessibility and being able to get into see a primary care? And then also, what options are there for bringing primary care providers back in terms of loan repayment and other creative ways? Are there things in terms of telehealth options to help with some of that access?

MRS. AVILA: Well, we are doing -- we have been doing a lot of initiatives towards those efforts. Precisely those are ones of the main areas that are covered by the new model. We are just, for example, guaranteeing
that the doctors are not going to have any reductions in rates until September 2019, just to see how the situation is developed, and most of them have approached us and really they are waiting until next year to see how things have been developed in terms of budget, in terms of fee schedules and rates.

In terms of initiatives to do better primary medicine and other alternatives to have some options for the doctors, we think the model first we have now presence of providers through the whole island. The beneficiaries can move from the northeast to the west region and look for providers across the island. That didn't happen before. They were limited by regions and the access was more complicated. That's one of the first options.

Also, we are dealing with high utilizer programs. We are just doing treatment plans with case managers and connectors in the community just to go and do, I will say -- if I need to put it some way -- old medicine, when the doctor used to go to your door and see how the family are, home medicine, we are just trying to stimulate that in the new model.

Also, the government has been issuing some laws
in terms of tax relief for the doctors, the specialists, and they have that type of incentive. Also, we are working with new laws to protect the doctors in terms of malpractice medicine. And those are directly initiatives that are in place right now just to try to persuade the doctors to not leave the island.

Other supports that we are bringing to the managed care organizations, for example, 92 cents of every dollar needs to go to direct services. We are establishing the MLR in the contract that never have been seen in the states, 92 cents. These people were very, very happy with me when we put that in the contract.

[Laughter.]

MRS. AVILA: But those are the extremes. That's why I'm telling you that we have been looking for all the options within managed care that are allowed, because managed care have their restrictions, and we have been putting in place just to take the program to the next level.

Also, we have a lot of plans. We have been developing a fee schedule for the dental practices. That it was lacking of those comparisons.
And what we are doing with the managed care and the professionals is when they cannot reach to an agreement, we get in and we go and look for guidance. And we look for reasonability in terms of negotiations. Even in those lower areas that probably people will think there is no space to negotiate, we don't have any other options, and they need to look for a way to keep providing the services until this gets more stable.

And the other thing that we have been just improving, visibility with the IT systems. We are just putting in place the MMIS, the Medicare fraud control unit. We have been complying with all those requirements from the federal government, and I can say today that CMS now has visibility of what Puerto Rico is doing, where are the services that are being performed, what is the cost of the model. They have that already. They didn't have that on January 2017. So, in two years, we have -- what we have been working hand by hand with CMS just to cover all those areas that were uncovered at the time that we getting the administration, and those are many of the efforts.

Others we need to put more -- for example, we have -- normal deliveries are decreasing because doctors
have a lot of risk just doing normal deliveries. We don't have any of the drug that is used for less pain in normal deliveries -- we say the epidural. It is not under our coverage. So how can we incentivize the OB/GYNs to do normal deliveries if they don't have those things in coverage? So those are the things that we are changing in areas that are needed to be adjusted in the short term, just to keep some balance in the system in the meantime.

MR. GONZALEZ: If I may, just to follow up. When we look into our access to care on the primary care level, I think the system in general, it's okay at the primary care level. Waiting times are usually lower.

We do have issues with certain specialists. That, you know, a member, for example, to get an appointment with endocrinology, it could take two to three months. You're talking about diabetes patients.

Nevertheless, I want to call the attention to the chart that I show because right now the older doctors are the ones who stay in the system. That's going to change. Unless something is done, in a couple of years, those guys are going to retire, and what's going to happen is that we're going to have a huge shortage of all sorts of
doctors, including PCPs.

I think at this point, we are okay when it comes to access to PCP, but I'm very concerned with what could happen in the next few years.

MS. AMADOR: I would like to include also that we have to -- with the issues that the new system, electronic medical records and some additional requirements, a lot of older doctors are shutting down their offices and coming to the FQHCs to work with us, and also you have to put into perspective why the research doctors are leaving, because a generalist salary in Puerto Rico is around $80,000. If you compare to the States, that is 175- to $200,000-plus. So there is just a big difference just in the salary if they decide to come to the Mainland.

Also, we try to retain them with the FTCA insurance, the federal coverage, so they don't have to spend more money on their coverage.

The loan repayment programs that we have as federally qualified health centers, we pay them quality incentive, retention balances. We pay them all the licensing they need to provide services. We provide them additional staff, staffing, so they can concentrate in
working with the patient and not feeling all the recommendations, all the other things they probably need to spend time on that.

So for us as federally qualified health centers, we have to rethink on the ways we can retain doctors because they are the ones who allowed us to bill for our services. If we don't have doctors, we don't have billing, so we don't have any revenues or any money. So we have put in a lot of investment in our doctors, even giving them the opportunity to work less based on production. So, as soon as they finish their patients, they can leave early to their houses and have more time.

Also, another way that we are retaining doctors is having additional contractors within our system to cover lack of doctors in certain areas.

Also, as Angie and Orlando says, specialties are very difficult to find. Appointments sometimes get to four or five months. So we are starting to contract and have specific specialties in our centers, such as endocrinologists, gastroenterologists, pulmonologists, neurologists, cardiologists, internists in our facilities, so they don't have to go outside or they don't have to wait
a long time for an appointment.

CHAIR THOMPSON: We are already just a little bit past our time, but I'm wondering if you can just stay with us for a few more minutes because we've got a couple of other Commissioners who would like to ask some questions.

MS. AMADOR: Yes.

CHAIR THOMPSON: We want to take advantage of your being here to make sure that we cover the issues that we're interested in.

So I've got Brian, Toby, and then I'll wrap up.

COMMISSIONER BURWELL: So I'd like to build upon some of the graphs that you provided, Orlando, around the high incidence of chronic conditions in Puerto Rico and the relation of that to access to prescription drugs and the high cost of prescription drugs. Could you just talk about are people not getting access to the kinds of drugs that could manage these conditions, and how much of it is access? How much of it is compliance? Are people getting the medications that they should be getting to manage these, these illnesses?

MRS. AVILA: In terms of covering medications, we are taking care of our patients, have the treatment up to
date. That's -- right now, that is not the main problem.

It was we have the resources to continue until 2019 with the $4.8 million -- billion dollars that were assigned to us as 100 percent parity.

So the operations are still stable right now. People are getting their treatments and their services, and moreover, with the new model, what we have done is to identify the high-cost, high-needs populations. And we identify the population, and we have -- implement an structure of payment by the rates, not by the capped premium amounts. We changed that to pay by the classification of those patients, and we will pay more for a cancer patient, that for a healthy member in the system. That way, we are just assimilating the specialist and their managed care organizations to bring us treatment plans, specific treatment plans for those types of high-cost, high-needs populations. And that assures us that that patient will -- we will ease their life just giving services, and we are trying to put all those services in multidisciplinary settings, and they will be provided by the drugs that are available for that treatment and a very focused treatment for that type of diagnosis.
And that's the way we have been approaching this in this new contract. I don't know if Orlando may add something.

MR. GONZALEZ: Yeah. No, I agree at the drug side. It's really not the issue. Patients are getting their medication. Actually, you see the access in Puerto Rico and because of the concentration of high number of patients, poor patients with chronic conditions we get, a patient in Puerto Rico gets about 55 drugs a year on average versus in the States, it's about 40.

So Puerto Rico, in terms of drugs, the access to drugs, the problem is that treating chronic conditions is more than just the medications. You need centers of excellence. You need nutritionists in the case of diabetes. You need to deal with other professionals. You got to deal with social workers because many of these people have a lot of conditions on environment, so-called "social determinants of care," but in reality, it's people that have poor nutrition habits. They don't have transportation in order to get to their appointments sometimes. They don't have the support of family members.

In order to create the infrastructure to serve
those chronic patients in a comprehensive way, the way that it should be done, there's no resources. So the drugs are covered, but that's not enough to really keep their conditions under control.

COMMISSIONER BURWELL: Thank you.

COMMISSIONER DOUGLAS: Just a quick final question. Back on federally qualified health centers, I'm wondering with HRSA if there's any investments or special funding that HRSA has been doing to invest in access points.

MS. AMADOR: Access points are being opened. Every year, in Puerto Rico, there's new access points. HRSA has given us a lot of money in the last two years, especially for Zika issues in Puerto and now for the hurricane recoveries and emergency preparedness and also for behavioral health. There's big issues with opioids and mental health issues also on the island, so we're receiving funding from them.

But we keep the same funding amounts we have been receiving the last years. So if there's no supplemental funding, we are being in the same base grants that we received in the last years.
CHAIR THOMPSON: Okay. I have just a couple of last questions. So one is I'm going to build off of where you were going, Toby. As I think about this and the story that you've told us today and the information that you brought, our charge is to talk about long-term sustainability, but there's a few steps that you have to go through to get to long-term sustainability.

You first have to stabilize the system in crisis, and then you actually have to strengthen it, so that it can perform successfully. And then you have to set the conditions for ongoing performance. So I think before we get to sustainability, we have to maybe think in terms of some other buckets.

And I'm not sure that I totally have the picture, and I just want to invite you to comment on this, otherwise we'll just load this all on Kacey to solve the problem for us -- about where all the other streams of funding are in terms of filling in the picture so that we understand from a Medicaid and CHIP standpoint what is it that we need to contribute and where are the dependencies for other contributions and investments, whether from other federal programs or other sources, including the private sector or
other sources, so that we understand.

I mean, those dependencies, for example, on workforce, there's only so much that Medicaid and CHIP is going to be able to do in terms of solving that problem, but if we're developing a funding approach and a financing approach that's dependent upon some other investments and some other results with respect to attracting workforce and retaining workforce, then we need to have that in mind as we think about what the success of our approach is.

So one is to understand where those other investments are needed, what the sources are associated with those, and how it fits into what we would be suggesting that Medicaid and CHIP do.

And then the other is I'm not sure that I totally understand how the Fiscal Oversight and Management Board fits into all of this. So I think I need a little bit better sense about that contextual environmental and what either opportunities or constraints that provides as we think about what we could suggest.

But some of this is just understanding our place and the larger context, and so any general comments or directions that you would like to provide to us to
MRS. AVILA: I would like to start in that matter, and thank you for the opportunity because always I would like to speak about these topics for a long time. And today, it is possible for me and so thank you, and bear with me. It's a language barrier, and I try to be as clear as possible.

In terms of how we can identify other opportunities with the agencies, we work closely with CMS, HHS, and HRSA. Like in any place, sometimes when you work with the government and sister agencies, the communications sometimes can be better, and we can do some planning on how to interface with all these grants.

And, for example, we have the federally qualified health centers. They have their own funding assigned by HRSA, but the government, the local government needs to do a wrap-around payment and some commitments to that effort. And this has been difficult to get to some collaborations and to maximize the funding because right now, as Ms. Amador is saying, if the federally qualified health centers cannot comply, they lost their grants, but if the local government cannot make the wrap-around
payments, they are going to be in noncompliance as well.

The wrap-around payments has been a financial constraint and challenge for Puerto Rico. We are talking about we expend more than $120 million a year in wrap-around payments. So the local government needs to identify those resources to be able to comply and have the federally qualified health centers on top. It will be great for them to have a full grant. That would be a dream come true, but that is something that we will need to work with HRSA.

On the other hand, with CMS, we are in a reimburse program, but even doing all the same things and complying with the same requirements, Puerto Rico always needs to wait longer to have the grants assigned, longer to have the authorizations, and that causes us a lot of problems, even with the organizations that have a sense of what is happening, Puerto Rico is not complying, is doing things that are not accordingly, and it's none of that. It's only that we are complying with some requirements, and the federal government in those offices have their lack of resources as well as Puerto Rico.

We have two persons only assigned to review a whole implementation of a new model. They ask us for 60,
90 days, until we can ask for reimbursement in those programs. That doesn't happen in other states or territories. Why? I always ask why because you heard there is a lot of mismanagement. If they say that Puerto Rico has a lot of waste, fraud, abuse, my numbers doesn't say that, and we have come to get used to those type of criticisms. And it's not that we are denying or accepting. It is the facts are that the numbers doesn't show those behaviors, and we have been penalized for that.

And it's very frustrating just to work from sun to night because we don't stop working. That's the reality because this is not a story. This is real, seeing an island of more than 4 million people just getting depleted every year, and seeing that my people is in this state. We have more than 6 million Puerto Ricans in the States.

And you know what? They want to live on the island because we like to live in the island, and I have been seeing that -- I'm sorry. But you're seeing that is happening in a slow pace, and it has become the time that nobody is looking. But the island in two years probably will have 2 million people, and the Puerto Ricans aren't going to be living here. And it's going to cost a lot, and
it's going to be a lot of situations.

So if CMS and HHS and HRSA, if we really put our efforts together, I know we can accomplish better things for the island, and we have to support and everybody have great intentions. But at the end of the day, I am still from October 31st and I'm -- like today is December 13 or 14 -- 14, and I haven't had the authorization for Puerto Rico to move ahead with the new system.

And you know what I need to stand in the island?

Ah, it is because Puerto Rico is doing wrong things or things in closed doors, and it's doing -- and it's not going hand by hand with the federal government. And that's not true people, and that's what they heard there. And that's how the noise start, just develop, and it ends like, oh, Puerto Rico is corrupted or is doing something bad because it doesn't have the money. And that is not the reality.

We have been complying with all the agencies. We have been presenting for my projections, and nobody listens. And that's the -- what we are just living day by day.

On the other hand, talking about the fiscal
board, the fiscal board doesn't allow us to include any number in a projection if I don't have the certification from the federal government. We used to do our projections based on what CMS was announcing and what the Congress was putting aside for Puerto Rico, and I cannot include any projection because I don't have the document that said that it's going to be for Puerto Rico and is certified. And that is part of our daily -- everything that we do, every contract, every negotiation needs to be approved by the fiscal board in advance. Even though we have the grant, even though we have the certification, they need to approve.

And you know what? They have been approving because I have been personally with the governor, with the health secretary of Puerto Rico, with our resident commissioner, going in front of them and saying, "Do you know what? If we don't have a healthy population, we are not going to be able to bring the economy to the place that we can cope with what has happened."

You know what as well? That we came to this point because Puerto Rico didn't bring the message correctly. Puerto Rico was getting to negotiations to
allowing, just accepting on funding to keep a system that was not at that price, and nobody said in the Congress and stated that. And that's why our doctors were just receiving less money, and we get used to that. And that's why I'm telling you there is no more room and space to keep that pattern. We need to change that pattern with evidence, with real information, with people that can talk the same language. That's what we have been doing these two past years, just putting the health together and bringing that message to you.

CHAIR THOMPSON: Thank you very much. Again, this has been extremely helpful. I think everyone has benefitted tremendously by having you here with us this morning. We appreciate your indulging us and our questions and staying past time.

Let me just see if there's any public comment that anyone would like to make before we take a break, and then we'll come back for more Commissioner conversation on this subject.

Just come to the microphone, please.

### PUBLIC COMMENT
MR. CINTRÓN: Good morning. My name is Allan Cintrón Salichs. I'm the executive director of a federally qualified health center in Puerto Rico, Consejo de Salud de Puerto Rico Inc. I'm also the president of the board of the Puerto Rico PCA Association. I do have some exact numbers here of the number of physicians that have left the island since 2009-2014, which I'm going to read for you.

In the time frame comprised between 2009-2014, the total number of physicians available in Puerto Rico dropped from 13,452 to 11,888, which is equivalent to 472 physicians per year or 1.29 physicians per day. This is a reduction of 17.5 percent, according to the statistics supplied by Customer Researching in December 2014. Most of these were specialty physicians. As a matter of fact, the number of specialty physicians dropped from 8,452 in 2009 to 6,713 in 2014, which is equivalent to 347 specialty physicians, almost one per day. Those are the true numbers in Puerto Rico. It is a dramatic situation.

I think all that has been discussed here is not a matter of challenging whether the plenary powers of the Congress over Puerto Rico, but it is about the people of Puerto Rico. This is the government of the people, for the
So we do have a problem here in Puerto Rico. We are required to comply with all federal laws, but we don't receive the same amount of funding. There is a disparity there that needs to be taken care of.

According to the Fifth Amendment of the Constitution of the United States, we are to have equal protection of the laws. Under the Medicaid law, we are simply not having the same protection. I think that is a problem that has to and needs to be addressed at some point. It's an old, old, very old problem, and in the case of Medicaid, Medicare, CHIP, it's about life. People are simply dying in Puerto Rico. We see that our health care center will delegate access to services because they can afford it, because we don't have enough funding because we don't have the medical physicians, the specialists, to take care of. As Orlando said before, it could take you three, four, even five months to see an endocrinologist in Puerto Rico. That is not good medical practice.

Thanks.

CHAIR THOMPSON: Thank you. And, also, if there are any data that any of the public think can be useful to
us, I just want to encourage you to go ahead and just --
you can get our contact information through the website and
send that on to us. Having the sources and the citations
helps us as well, using that information.

MS. LULINSKI: Good morning. My name is Amie
Lulinski, and I'm the project manager for a longitudinal
research project called "The State of the States in
Intellectual and Developmental Disabilities." The question
was raised asking about the number of pregnant women and
children that this impacts. I would encourage the
Commission to also consider the number of people with
disabilities this impacts, particularly people with
intellectual and developmental disabilities, those who are
medically fragile and those who are technology-dependent.

And the second comment that I would like to make
is I am so very glad that this is being brought up in this
kind of forum about the conditions of Medicaid in Puerto
Rico. I would also encourage the Commission to consider
the situations in the U.S. Virgin Islands, Guam, American
Samoa, and the Commonwealth of the Northern Marianas
Islands.

Thank you.
MR. LAWS: Good morning. My name is George Laws. I'm the deputy director of the Puerto Rico Federal Affairs Administration, which serves as the Washington, D.C., office of the Governor of Puerto Rico, Ricardo Rosselló. We greatly appreciate the opportunity to have MACPAC hear about this issue in greater detail, and in response to the question about the broader context of federal funding that can be brought to bear, I would like to bring the attention of the Commission to a requirement that Congress established as part of the Bipartisan Budget Act, which is for the Government of Puerto Rico to present to Congress an economic and disaster recovery plan. That economic and disaster recovery plan is a comprehensive plan that establishes a number of different areas of capital investments that need to be addressed as part of the recovery and reconstruction process. That plan was submitted by the Government of Puerto Rico to Congress on August 8th. I've shared a link to the document with Kacey over email just as we had that question come up because I thought it would be a very useful context for all of you to have. And one of the areas of capital investment, of
course, is health care and our health industry, so I would greatly encourage MACPAC to also utilize that context when it's doing its analysis for the stabilization as well as kind of the long-term sustainability question for Puerto Rico's Medicaid but broader health care system. Thank you.

CHAIR THOMPSON: Much appreciated. Thank you.

MS. HEREDIA RODRIGUEZ: Good morning. My name is Carmen Heredia Rodriguez, and I am a reporter, and before I start, I want to make sure that it's okay for a reporter to ask questions.

CHAIR THOMPSON: Sure. You're a member of the public.

MS. HEREDIA RODRIGUEZ: Great. Thank you. I appreciate it.

[Laughter.]

MS. HEREDIA RODRIGUEZ: So Ms. Avila in her presentation mentioned that continued money from Congress, in addition to the $4.8 billion, would enable Puerto Rico to be able to provide certain services like long-term care that's not being provided now.

Another service that I'm curious about is
providing curative hep C medications through Medicaid. I know that Medicaid here in the states has fought and in a lot of states won to provide those. So I'm curious to know, first of all, whether Medicaid covers curative hep C medications, and if not, if there are any plans to use the $4.8 billion that they received from Congress in order to provide that new coverage.

CHAIR THOMPSON: Thank you. Normally I will say we don't -- it isn't so much a matter of asking questions but taking in public comment. But, Angie, if you are interested in responding to that, I encourage you to do that, or you can do so after the meeting.

MS. HEREDIA RODRIGUEZ: I appreciate it. My apologies.

MRS. AVILA: Well, it is a short answer. Hepatitis C is covered for the HIV patients, and now Puerto Rico is doing the identification of the funds to include hepatitis C for all the patients in coverage.

MS. HEREDIA RODRIGUEZ: Thank you, Ms. Avila.

CHAIR THOMPSON: Okay. Thank you.

Again, many thanks to all of the public and to our panelists. We appreciate your coming and spending
We appreciate the future help we will no doubt call on you to provide as we continue to investigate this issue. We will take a short break. We are a little bit behind time, but let's take 10 minutes and come back just about five of 11:00 to pick up our conversation.

### FURTHER DISCUSSION OF MEDICAID IN PUERTO RICO

CHAIR THOMPSON: Okay. Again, Kacey, thank you for all the work you did in preparing for that panel discussion. It was, I think, extremely useful.

We are a little bit behind time so here's what I'm going to suggest. I think there were a number of questions and areas of exploration that came out in that conversation that I think, Kacey, you have made note of in terms of thinking about how do we pursue or explore some of those areas. What I want to do is give the Commissioners, you know, an opportunity to add to any points that weren't discussed in our last session, in terms of areas that you think we need to kind of add to the list of things that we're interested in or we think, hearing the conversation, really need priority in terms of exploration. And I then I think we'll go ahead and sort of organically just catch up
on our time that way.

Toby and I were just having a little bit of a back-and-forth, that both of us were actually wondering also about Medicare. We didn't get a chance, really, to get into that part of, again, sort of this contextual piece about, you know, where all the places where we need to have at least an understanding of where federal money is coming into the system, or other kinds of money are coming into the system. Both Medicare beneficiaries, generally, and what's happening to them in the system, and then duals.

MS. BUDERI: I can try to answer that question. I'm not as familiar with the Medicare side, obviously. I think there are some issues with federal treatment under Medicare that affect Puerto Rico. One of the things that was also a contributing factor here, because Puerto Rico is very reliant on Medicare Advantage, they were disproportionately affected by cuts to Medicare Advantage over the last several years. I think there are some things in the way the Medicare DSH formula works, that affect it because of its -- because of the SSI factor and Puerto Rico not participating in SSI. So that's a little bit uneven.

I know there are about 250,000 dually eligible
beneficiaries, so it's a pretty relatively high percentage.

Beyond that I can't tell you much today but I can
definitely look into it and see how it plays a role.

COMMISSIONER BURWELL: But spending for duals was
probably much lower in Puerto Rico because of the lack of
coverage for LTSS. So it's mostly --

CHAIR THOMPSON: Right.

COMMISSIONER BURWELL: -- copays and deductibles.

CHAIR THOMPSON: Martha, you were going to jump
in, and then I think, Phil, did I see --

COMMISSIONER CARTER: I was actually -- yeah,
changing the subject a little bit, I mean, it's clear this
is a real crisis. I mean, I think we all feel that.

I was looking through the Puerto Rican Health
Center rollup data and I'm struck by a couple of things.

Ninety-nine percent -- this is was in the presentation --
99 percent of their patients are under 200 percent of
poverty. That's higher than any place else.

They don't currently, or maybe they're just in
the process, I think Gloria told me, of creating mechanisms
to have -- nurse practitioners and physician assistants,
they actually don't have that workforce. They don't have
that in Puerto Rico, and nurse midwives, or at least not in
the health centers, and it doesn't seem like they have much
in Puerto Rico at all. So to your point, most of their
physicians are GPs rather than family practice, and they
don't have that additional level of workforce that's
available to the rest of us. So that might be something to
consider, even recommending, that that would help them.

The other thing that jumped out at me is a lot of
their quality metrics have gotten worse over the past year.
Makes sense. Their low birth weight rate -- I have to
always do that slowly -- their low birth weight rate has
gone up over the past year. So, I mean, we definitely have
an impending health crisis. I mean, it's financial but it
shows in these numbers that I'm looking at, so I think it's
really important.

CHAIR THOMPSON: Thank you. Bill.

COMMISSIONER SCANLON: I'm going to say, as I
said it in the hall, that I agree with you that there's a
question of what should be done about the short-term crisis
and in thinking about that in the broad context, and then
what needs to be done in the longer term, also in the broad
context of some of the factors may change.
In that longer-term consideration, I think that some examination of what maybe a good FMAP might be, as opposed to the current formula that we have, and I say that having sort of been involved with work on the FMAP, where you think of sort of three factors. You think of a state or territory's ability to pay, the need for care sort of in that area, and then the third thing being the cost of care, which we raised -- which was discussed a little bit yesterday.

And so now what would be -- the proposal we heard this morning was, you know, to revert to the current formula, after 2021, but I think that we think about it sort of as maybe an opportunity to start to consider what might be some adjustments to that current formula.

And then the last thing I would say is that the territories should be looked at sort of in their entirety, because I don't know if there's any situations on a longer-term basis, in any of the territories, that deserve attention from us, from a Medicaid and CHIP perspective.

CHAIR THOMPSON: Kit and then Sheldon.

COMMISSIONER GORTON: So I agree with Bill wholeheartedly, on the last piece. We shouldn't just look
at Puerto Rico. The Virgin Islands got hit as badly with
the hurricanes as Puerto Rico did, and Guam just got
walloped. So, you know, I think that we should broaden our
aperture to cover all of the territories.

I'm struggling a little bit because we talked a
lot about numerator numbers and we didn't have a lot of
denominator numbers. And so, okay, so we've dropped X
thousand physician providers. What's the population done
in that period of time? So I just -- I want to make sure
that we're in context and that what we're thinking about in
terms of sustainability is not the situation on the ground
five years ago but the situation that's likely to be on the
ground in the next 3 to 5 to 10 years. So that's one
point.

The second piece, and I talked about this a
little bit the last time, is I do think we need to have the
right context as we look at these numbers. So we heard
outrage expressed because it might take four or five months
to get an endocrinology appointment for a person with
diabetes. I'm here to tell you that if you could get an
endocrinology appointment for a person with diabetes in
Fairfax County, Virginia, in four to five months, you would
be feeling really good about having been able to do that.

So it's very important that we -- I'm not diminishing, at all, the pain and the stress and the difficulties that these folks encounter, but they are in this and they don't necessarily have a perspective about what it's like everywhere else. And I think the other piece of context is if we're going to talk about what we're paying people, then again we need to have benchmarks. A general practitioner, quite frankly, can't get into most managed care networks in the States because they lack the qualification of being board certified in a specialty. But if you're a board-certified specialist in a primary care specialty, in a managed care network, I don't think many of them are making $200,000 a year.

And so, you know, we know what the salaries for those are in the States, and we need to be sure that what we're coming is apples to oranges. So I just think that it's important. I think the numbers they brought us are illuminating. But as we put together our recommendations for Congress I think we need to say, you know, the data are available in terms of comparative cost of living. The data are available in terms of other things. I think it's
important that they pointed out that they're subject to all
of the same requirements that everybody else is, and that's
a problem because I'm not -- I'm reasonably confident,
based on what we've been shown, that they're not receiving
a level of federal funding to support their compliance with
the federal requirements. So I don't have any quibble with
that.

But I think as we think about the longer-term
sustainability piece we really need to come back to, you
know, what's the target here. You know, what is a
reasonable aspiration? And that should inform our thinking
about what the right FMAP is and some of these other
things.

CHAIR THOMPSON: Let me just comment on the
question of the right FMAP and whether or not that's
something we -- I mean, I think there's a question about --
and maybe, Anne, you want to jump into this in terms of
what the request is from a standpoint of timing, if nothing
else. I mean, because this is a subject, as we've seen,
that we can ask a lot of questions, and even think about
broadening, as we've all discussed, broadening the question
to include a consideration of what's happening in the
larger economic environment, or what's happening with other federal streams, or even potentially we talked before about how does this compare with things that are happening in other states and territories, as an understanding.

And then thinking about the shorter-versus longer-term question, are we aiming towards a recommendation, as a question, right? I mean, should we make a series of recommendations? That lift is pretty substantial for us to go through the process to be able to do that. It still might be worth doing. It may be that we want to do this in a couple of steps, where the first thing that we'd want to do is we'd want to lay out our understanding of the issues and the problems and the challenges, and perhaps some areas of general commentary or observation, where we think there might be some opportunities to shape something differently in terms of program requirements, in terms with relationship with the Federal Government, in terms of how the funding flows, in terms of how different streams of funding are brought together, et cetera, et cetera, with an idea that that maybe provides a launching-off point for something further down the line or not.
I just don't want us to get too -- I don't want us to presume that what we're after, unless the Commission decides that it really has the appetite to do that and the wherewithal to do that, that we're going to come up with something that is a series of recommendations that includes something as precise as what is the FMAP. I just think that's a question about where we're aiming.

So I have Sheldon and then Alan and then Fred, and then Bill.

COMMISSIONER RETCHIN: I'm actually sensitive to what Kit raised. I don't -- I mean, I asked Kacey about physician density figures so that we can normalize this, and recognizing that is it even a different population in the island than on the mainland, because it's overwhelming Medicaid. So if you looked at the Medicaid mainland physician density I would say it's probably, or was, pre-hurricane, worse.

That said, here's where I guess I'm struggling is it's really moving fast. So there is this cliff that's ahead of us, and I think the longer that Congress waits on a decision, whichever way that decision is, that more will transpire and will it cost more?
What I don't understand is why isn't Florida, why isn't Governor Scott screaming about this with a cost so high on the out-migration? And then a fundamental question for me is, if we were to fix it, or if we were to help stem the tide, is the out-migration of providers and people, how much would that help? We're not going to be able to cure world hunger, but my sense is that we might be able to divert away from a humanitarian crisis and be able to help. And maybe, actually, on -- and I know it's not scored this way, but with all the out-migration now, which doubled after the hurricane, by the way, that we might be able to help that and, in the end, save a huge amount of money for the Federal Government.

COMMISSIONER WEIL: I agree we need to take the scope of what we want to try to do, take that on carefully. I want to just put two bits of context. One is we jumped into the issue of Arkansas disenrolling 4,000 people a month in a way that made some people not so, you know, thought it was -- questioned whether that's our role, but it was important. I realize this isn't exact but the lawyer in me has to always go back to the statute. We're
supposed to have an early warning system to identify other factors that adversely affect or have the potential to adversely affect access to care by, or the health care status of Medicaid and CHIP beneficiaries. It's pretty hard for me to listen to this and think that we haven't identified something.

So again, I don't want to try to solve every problem. I completely agree. I have more questions than answers. But the notion that sort of we've been warned, I feel like we've been warned. So I just put that out there.

CHAIR THOMPSON: Which I think also -- I mean, that's something for us to seriously talk about in terms of the ability for us to shine a light on a set of issues by having a certain kind of information put together in a certain kind of context, again, without necessarily aiming towards we know what all the right answers are, is maybe something that is worthy, in and of itself, over the shorter term, and maybe then sets up the stage for, you know, continued work and ideas about things that can help solve that on the longer term.

Fred and then Bill.

COMMISSIONER CERISE: So, you know, there is a
bigger picture that I'm not sure we understand that --
maybe Bill does -- your comments about the territories and
how those are treated differently, because before the
hurricane there was a big difference in what Puerto Rico
had access to in Medicaid, with a smaller rate match than
you would have expected in a cap, and that sort of stuff.
So in one sense, if they just had the same deal
that Mississippi had, for instance, then it seems like that
would address the issues there. So I don't understand, you
know, the issues behind different territorial treatment,
nor am I asking us to get into that, but there is a much
simpler -- I mean, I don't think we can address that but we
could comment on this is what it takes to run a Medicaid
program for a population that looks like this. It seems
like that would address a lot of the issues.
So I don't know. Like I said, how do you
separate those issues? But we can certainly say this is
what Medicaid would look like, or should look like for this
population.
And I'll just make one other comment about
recovery, and that is, like others, I like the data, you
like to be data-driven, you like to understand sort of how
many per of everything that we have and need. In the midst
of recovery, and even after immediate short term but sort
of intermediate term, you're going to have to accept some
mismatches, just because people don't -- things don't
happen in order, you know. And so you lose providers
because they can't stay and do their business, and then
even though the population goes down you still have a
population but you lost, you know, your one specialist, and
so you have a big mismatch.

And so I think in the intermediate term,
certainly, I think we need to be comfortable with some
mismatches in providing some assistance that, you know,
might be more than the numbers justify.

CHAIR THOMPSON: And Fred, you have special
insight on this dynamic, and so I really appreciate that
warning, that we may not be able to have a sort of full
view into how all the pieces are going to fit together in
the right way so that everything comes together, that it's
going to be, well, this is the best we can do to get this
going, and to get this better, and then, in the meantime,
we'll try to fill in over here, and so forth. I think
you're trying to make sure that we don't try to make
everything to kind of policy-wonk perfect, from that standpoint. Okay. Not that we don't love our policy wonks.

Bill and Brian, and then we'll bring everything to a close.

COMMISSIONER SCANLON: Yeah. I just wanted to say, I'm kind of much aligned with Kit, I mean, and that was in some respects motivation behind my comment. So it was not to think about we're undertaking an FMAP study or we're leading to a very specific recommendation.

When you look at what's happened historically with the territories it's clear Congress made choices. They're not formula-driven choices, and I think that it would be useful here to provide information, that as they think about more choices or new choices, that they have information about how things might stack up relative, sort of, to alternatives. And that would be -- that's much short of the work that I think would be required to try and open up the FMAP and make a very specific recommendation.

CHAIR THOMPSON: Okay. Brian and then I want Anne to circle back in on the question of the other territories.
COMMISSIONER BURWELL: I raised this last time and I'm not really advocating for this, necessarily. But I would propose that we think of fairly dramatic changes to the Medicaid insurance model in terms of coming up with solutions. I mean, it is a significant problem that may require pretty radical differences, and there already are some differences. I mean, like one thing around the FMAP that, you know, in other states we pay federal income taxes and we get federal money back. In Puerto Rico, they don't pay federal income tax. So it is much more of a grant program. So that's just one thing.

And also, some of the other things, you know, if it's just a major 1115 or whatever, getting around the Medicaid best price thing, if it's a non-Medicaid program then it doesn't have to comply with that, or all the Medicaid requirements and administrative oversight. You know, we may want to just propose a model that's just a lot simpler in terms of federal-state interaction and administration.

So I think we should be fairly kind of creative and bold in terms of -- I'm not saying that's the answer, but I think we should at least investigate fairly radical
changes.

CHAIR THOMPSON: I don't know about characterizing it as radical, but Toby and I were talking along the same lines. You may be just going further with that, in terms of where are there opportunities to streamline, to unify, to alleviate burden, to increase agility between the federal and the territory government, in terms of how to proceed.

So I think -- in fact, I think we heard some of those potential pieces of opportunities, and we've discussed other areas, as a Commission, in the program writ large, where we think maybe there might be some opportunities to test out here.

So I think there's that whole range of, you know, possibilities, from very pointed ideas about here might be some particular areas where we want to make some adjustments and the commonwealth's responsibilities, vis-à-vis Title 19, where a few surgical places of relief would make a big difference versus, you know, something more wholesale.

But I think that's right. That needs to be on the table in terms of thinking about program structure and
COMMISSIONER BURWELL: What is our deadline, Anne?

EXECUTIVE DIRECTOR SCHWARTZ: Well, that's actually what I was just going to turn to. The request actually doesn't have a deadline in it, but if the territories' ability to use this money is going to run out in this fiscal year, I think this needs to be in our June report. I mean, there's value in continuing work in this area, but certainly we should be talking about it for then.

And to that point, we have heard, not just from you but from several other folks, that, you know, "Why are you just doing Puerto Rico? You should do the other territories too." And I think that's a fair point but I'm also a little bit concerned because each territory is quite different. I mean, Puerto Rico is clearly the biggest of the territories. We're trying to get our arms around understanding the situation in Puerto Rico. To the extent that we'd have to try and do that for the other territories too, it's a whole additional set of facts.

So I just want to temper the expectation that we can do it all at once, but maybe think about how we can
take on some of those other issues in maybe a more modest way.

I also just want to say that the national average salary for a family physician is $219,000.

CHAIR THOMPSON: I think the June report that we're talking about --

COMMISSIONER GORTON: I retired too soon.

CHAIR THOMPSON: -- in order to think about a recommendation, set any recommendations. So let's just walk back from that timing, because I'm also concerned about that seems a long time to not say anything, so apropos. So I'm just trying to think about, can we segment this? Maybe there's an issue brief that we could issue, with some of these things, in the next month or two, that we could look at at the next meeting, with the idea that then that gets expanded on, maybe with some recommendations for June. You know, I don't want to like just hold it all because we don't have it all.

EXECUTIVE DIRECTOR SCHWARTZ: No. I mean, we have three meetings before the June report. We have January, we have March, and we have April. We already have an issue brief that contains much of the material that was
reflected in your background materials, at the last
meeting, that Kacey prepared, that -- I mean, I don't know
how out-of-date it is at this point, Kacey. You know
better than that. So it's not like we don't have anything
out there.

So, I think we need to think about what other
information we need to assemble and focus on to be able to
lead you to where you want to be.

I also just say, I mean, if you want to do
recommendations, you know, we're here to support you in
doing recommendations. I do think a report that sheds
light on things, as you said, Penny, is of value as well in
showing some of tradeoffs. So I don't think if you don't
do recommendations, if you can't find, you know --

CHAIR THOMPSON: Yeah. This is all the art of
the possible.

EXECUTIVE DIRECTOR SCHWARTZ: Right. I think
both of those have value.

CHAIR THOMPSON: So can we -- I mean, we don't
need to engineer it, and we're not going to engineer it
here. Can we just ask for you guys to go back? Let's at
least touch base on this subject at our January meeting,
and maybe, depending on how things -- how you think about this conversation and digest it, there may be something that we could expand on in terms of an issue brief. There may be some things that we might want to particularly say to the Congress in light of this request, about the status, that could include some observations and some level of concern that we might want to express. That's a possibility.

So let's just think about it. I think, in the end, what I would -- I mean, we're obviously aiming towards a fairly major chapter in the June report, but I think we really ought to be looking at opportunities ahead of that, to make some kind of communication.

Okay. Any -- oh, Sheldon.

COMMISSIONER RETCHIN: Yeah, I just want to say I know we've been at this before, on the territories, and just to point out that Puerto Rico is 92 percent of the population of the territories. So in any recommendation we make it really is dominated by the Puerto Rican situation.

CHAIR THOMPSON: Thank you, Sheldon. Kacey, again --

COMMISSIONER CARTER: Can I say something really
fast? When I talked about the quality measures I want to make sure that I go on record saying that I wasn't actually ding the health centers at all for that, that a lot of these measures have to do with access within the rest of the health care system, or social determinants. So I didn't want to be sounding like I was criticizing them for this.

Chair Thompson: Thank you for that clarification. I think we were all following you, though. The challenges that they're facing are going to inevitably have impacts on their results.

Okay. Kacey, thank you again. Great morning of conversation on this subject, really much appreciated.

All right. So we have a slight challenge on the schedule.

Executive Director Schwartz: We will get there.

Chair Thompson: But we'll see what we can do.

So we're going to have a short presentation on MACStats, the much beloved and looked-forward-to reference book, and then we'll take a pulse on where we are on the program integrity side.

[Pause.]
*** HIGHLIGHTS FROM THE 2018 EDITION OF MACSTATS

* MR. PARK: All right. I wasn't sure if you guys were ready.

  CHAIR THOMPSON: Oh, sorry.

  MR. PARK: No problem.

  CHAIR THOMPSON: Trying to figure out the next session.

  MR. PARK: Just quickly, we're going to present some highlights today from our most recent edition of MACStats, which was released last week. Much like the actual production of MACStats, I'm going to let Madeline do all the work, so that is it for me.

  [Laughter.]

* MS. BRITVEC: Thank you, Chris. Glad to do all the work again.

So MACStats is divided up into six sections -- five main sections, and then a technical guide. We're going to go through just the key components of each section today.

Section 1 goes into just the key statistics on Medicaid and CHIP enrollment and spending.

Section 2 focuses more on the trends.
Section 3 elaborates on the state-level and eligibility group as well as type of service and other factors.

Section 4 goes into the eligibility determinations, and Section 5 focuses on survey data.

The 2018 edition of MACStats includes 11 reprinted tables which show 2013 and 2014 enrollment and spending data. These tables could not be updated due to lack of available data caused from the transition from the Medicaid Statistical Information System, or MSIS, to Transformed MSIS, or T-MSIS.

All states have begun submitting T-MSIS data to CMS, but these data are still being verified for completeness and accuracy, so they are not yet ready for publication. Once they are, we will update these tables on our website.

Section 1 of this year's MACStats shows similar trends to last year. Over a quarter of the country's population was enrolled in Medicaid or CHIP for at least some part of fiscal year 2017. Medicaid was 16 percent of states' budgets in state fiscal year 2016, and Medicaid and CHIP held a slightly lower share of the national health
expenditures than Medicare in 2016.

So now getting into the trends of the data, over the last five years Medicaid and CHIP enrollment has increased by over 27 percent. The bulk of this change happened in the first initial years of the majority of the ACA expansion. Since July 2015, Medicaid and CHIP enrollment has had a steady increase at about 1 percent each year; however, in the past year, from July 2017 to July 2018, there has been a slight decline in enrollment.

Furthermore, this graph shows the trends and growth rates. Spending and enrollment have had a complementary growth trend, both rising and falling, compared to policy changes and economic shifts. In recent years, the growth rate for full-year enrollment and spending both have declined, but they are still experiencing a positive growth rate at about 2 percent each.

Similarly, Medicaid and CHIP are both holding a stable share of the federal outlays. In 2017, CHIP was 0.4 percent of total federal outlays, and this showed no difference from the previous year. Exchange subsidies have increased to 1 percent. Medicaid's share has decreased
slightly from 2016 to 9.4 percent, and it's still less than Medicare's share, which is about 15 percent.

All right. Exhibit 13 compares Medicaid's share of the state budget, so when we compare state funds, we can see that both state general funds and all state funds remained fairly stable and constant over the past four years. However, when we add federal funds into the mix, you can see that Medicaid's share of the state's budget increases over recent years, and this is due to the increase in FMAP for the new adult group post expansion.

Section 3 shows that the use of managed care continues to increase. Capitation payments for managed care were about half of all Medicaid benefit spending. Over two-thirds of Medicaid enrollees are enrolled in comprehensive managed care, and in fiscal year 2017, net drug spending decreased slightly from the previous year.

Just as a note, Section 3 is where you can find most of our republished MSIS tables.

As you will recall, last year we included a new table, Exhibit 23, on the full-year equivalent newly eligible adults and their spending compared to all full-year equivalent enrollees. Like last year, spending for
full-year equivalent enrollee was less for newly eligible adults than for all Medicaid enrollees. Spending per newly eligible adult has decreased actually from the past fiscal year, fiscal year 2016 to 2017, but spending per all enrollee has grown modestly.

There were not any substantial eligibility criteria changes in the past year. In 2017, 42 percent of Medicaid enrollees had annual incomes less than $12,140 for a single individual. Thirty-one states and D.C. are now covering the new adult group. Four additional states have approved Medicaid expansion but have not implemented it, and that excludes Virginia, which has just started the implementation process.

So Section 5 of MACStats reports survey data from the National Health Interview Survey and the Medical Expenditure Panel Survey. Results from this section were very similar to last year's data. In 2017, those covered by Medicaid or CHIP reported having a usual source of care at a higher rate than those who are uninsured, but slightly less than those who are privately insured, and Medicaid and CHIP enrollees were more likely to have trouble finding a doctor than those with private coverage.
That concludes our presentation.

CHAIR THOMPSON: As usual, again, I think people really do look forward to getting the MACStats book, so thank you for all of your work in compiling that. There was a tremendous amount, we know, that goes on behind the scenes to make sure that this comes together, so congratulations again.

MS. BRITVEC: Not a problem. I hope you stuff your stockings with it.

[Laughter.]

CHAIR THOMPSON: Questions from the Commissioners on the results or the process?

[No response.]

CHAIR THOMPSON: All right. Thank you again. Jessica, we're going to beg your pardon and ask if you will come back and have this conversation on program integrity at the next meeting. There is not an urgent time frame for this, and I want to be sure that Jessica gets our attention and we have ample time to discuss this and don't want to just sort of rush this in at the end of the agenda without having enough time for it. So we will just look forward to that conversation next time then. Thank you.
Any last remarks or questions from the audience, from the public?

### PUBLIC COMMENT

* [No response.]

CHAIR THOMPSON: Okay. We will bring our meeting to a close. Thank you, Commissioners. Again, very productive and good couple of days. Thank you.

* [Whereupon, at 11:33 a.m., the meeting was adjourned.]