PUBLIC MEETING

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

Thursday, December 13, 2018
9:38 a.m.

COMMISSIONERS PRESENT:

PENNY THOMPSON, MPA, Chair
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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

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1 P R O C E E D I N G S

2 [9:38 a.m.]

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

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

17 Chris.

18 **### PANEL: STATE INNOVATIONS IN DRUG PRICING**

19 * MR. PARK: Great. Thank you.

20 Today's panel continues the Commission's
21 discussion on Medicaid's coverage of prescription drugs and
22 the challenges states face in managing drug spending. Last

1 December, you heard about the management tools that states
2 currently use to control utilization of spending and how
3 the current tools are somewhat limited when it comes to
4 high-cost specialty drugs. Today's panel will further this
5 discussion by talking about the innovative coverage and
6 payment policies that they are pursuing that go beyond the
7 current management tools used by states.

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

17 Dr. Gee will talk about Louisiana's efforts to
18 create a subscription model to pay for curative hepatitis C
19 drugs for its Medicaid and prison populations. In August,
20 the state released a Request for Information on the
21 mechanics of how the subscription model would be
22 implemented.

1 Dr. Jeffrey is the Director of Pharmacy in the
2 Office of Clinical Affairs for Massachusetts Medicaid and
3 is responsible for the state's pharmacy benefit for
4 approximately 1 million of MassHealth's members. He is
5 also an Associate Professor of Family Medicine and
6 Community Health at the University of Massachusetts Medical
7 School and currently serves on the Board of Directors of
8 the Academy of Managed Care Pharmacy.
9 Dr. Jeffrey will discuss the goals of the
10 pharmacy proposals in the state's recent Section 1115
11 waiver request, which was ultimately denied by CMS, and the
12 state's payment policies for cell and gene therapy.
13 Many state and federal policymakers have
14 expressed interest in new coverage in payment policies to
15 address the high cost of certain drugs. While it is too
16 early to know what Medicaid-specific policies may arise,
17 given the upcoming changes in Congress, the innovations
18 that both states are pursuing may serve as models for
19 policymakers to consider in the future.
20 And with that I will turn it over to Dr. Gee.
21 * DR. GEE: Good morning. Can you hear me?
22 CHAIR THOMPSON: Yes, indeed.

1 DR. GEE: Good morning. Thank you so much for
2 having me. So I'm going to tell our story, because this is
3 a story more about strategy and need and communications as
4 it is about process and policy.
5 I started in this job in January of 2016 with
6 Governor Edwards, the only Deep South Democrat governor who
7 expanded Medicaid. I'm an obstetrician. The issue of drug
8 pricing was of note to me as an OB on the area of 17-
9 hydroxyprogesterone, which is a medication, the only
10 medication that reduces repeat prematurity, and because of
11 the very high cost, which was about a 1000 percent increase
12 over what we were able to compound, I was unable to get
13 that for my patients and had created a national quality
14 measure to look at improving it.
15 So I was aware of drug pricing but hep C came on
16 my radar for a number of reasons. One was that the
17 governor expanded Medicaid, so in July of 2016, we went
18 from a state where one in four people did not have access
19 to insurance to now an uninsurance rate -- of course, that
20 didn't happen immediately -- of 8 percent. So a tremendous
21 shift in our ability to manage population health issues.
22 And I also was appointed to the National Academy

1 of Medicine Panel on Affordable Drug Pricing, with Alan and
2 other distinguished members, and really started digging
3 into issues of drug pricing.
4 In approximately May of 2016, I received a letter
5 from angry constituents in the state not receiving
6 hepatitis C drugs and demanding access and threatening to
7 sue us. Similarly, right before taking the job of
8 secretary I received guidance from CMS saying you must
9 provide more hep C drugs. Coming into the job, the
10 governor and I faced a $2 billion deficit. We were at risk
11 of losing nearly every state general funded program in my
12 department. And so we looked at the numbers, and even with
13 the discounts it was daunting and impossible to do what I
14 thought we should do, which was to cure hep C. There is no
15 reason why we should have to wait for people to bleed
16 internally, to suffer, and some to die, to have fibrosis
17 and then organ damage, to treat a disease that is curable,
18 and one of the great, arguably, medical discoveries of
19 recent years.
20 And so this is very frustrating to me but I
21 really didn't have the tools to demonstrate the tradeoff.
22 Lots of policy experts nationally said, "This is a great

1 deal. What a fabulous deal. Value-based. Look at what a
2 fantastic value this is. You'll save money in the long
3 run." But we don't have a single-payer system, so for me,
4 by the time someone ended up with a liver transplant or the
5 kind of damage it really caused, they're on Medicare.
6 So I went to the smartest person I knew on this,
7 who is Peter Bach. I called Peter and I said, "Peter, help
8 me demonstrate this." He had developed an abacus of drug
9 pricing, particularly with a focus on cancer patients. But
10 he and I engaged in the first partnership, looking at the
11 state tradeoffs. So we created an abacus that really shows
12 all of the -- and using publicly available information he
13 was able to demonstrate the tradeoffs in state budgets.
14 And I have a zero-sum game, right. As a state
15 secretary I cannot print money. I cannot borrow from
16 China. It is a crime if I don't balance my budget. So I
17 cannot just go spend money on things, right? I have to cut
18 in other areas.
19 And so what we showed was to fund what I thought
20 we should do, which was the elimination of this disease, we
21 think we have -- and I'll go into these numbers -- at least
22 40,000 people with the disease, it would be about $760

1 million. That is 10 times our K-12 public spend. That
2 would have eliminated our Division of Administration, our
3 correctional system. It would have been nearly our entire
4 university spend for the entire state, and was an absurdity
5 and an impossibility.
6 So we were able to show that, and to experts, and
7 I started developing a relationship with folks like Jon
8 Gruber, because the Wall Street Journal called me and said,
9 "Well, Jon says it's a great value," and I said, "Well,
10 that's bollocks." And I Googled Jon and called him up and
11 said, "Jon, it might be a great value for you in
12 Massachusetts, but in Louisiana 40 percent of my people are
13 under 200 percent of poverty, we have a $2 billion budget
14 deficit, and it isn't a great value, at least not at a
15 population health level, because it's impossible. We
16 cannot solve the equation."
17 So I started building a team. So the first step
18 was to show the opportunity cost. The second step was to
19 reach out to Josh Sharfstein, who I knew through the Obama
20 transition, who I call the "public health Yoda." This man
21 is an incredible strategist and with an incredibly lack of
22 need to take credit for things. Anyway, so I called him

1 and started talking and he said, "Well, what about 1498?"
2 So 1498 is a federal law, most notably used for night
3 vision goggles. It's when the technology is really in the
4 national interest, whether it's national security or
5 national health. It was threatened by Tommy Thompson in
6 the wake of anthrax threats to reduce the price of Cipro.
7 It really has not been used for health in quite a bit of
8 time. And the idea was the U.S. Government would fairly
9 appropriate the intellectual property and then would be
10 able to then produce that drug.

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

19 And the feedback was incredibly positive. Tons
20 of public comment, tons of positive comments, but PhRMA was
21 hysterical. So within, really, hours of this -- and the
22 Washington Post covered, in a front-page story, some of my

1 work, and then it was the top bill of Politico, I believe,
2 here in D.C. And so within minutes I had pharmaceutical
3 lobby in Louisiana very concerned about this, right,
4 because nothing gets people more worried than intellectual
5 property and patents, and so on.

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

17 And let me give just a minute to why hep C. So
18 hep C, why? Hep C is the leading infectious disease killer
19 of our time. It kills more people than all other
20 infectious diseases combined. We have a registry, started
21 before my time, of 90,000 people who have hep C in our
22 state.

1 So this was a public health crisis, a public
2 health challenge. And so it was not only about the -- and,
3 actually, for me, really it wasn't about the issue of drug
4 pricing. What I was trying to address, and we were trying
5 to address, and the governor was trying to address, is the
6 fact that we have people suffering, and who are ill and
7 dying. When people in other countries have cure within
8 reach, we didn't, and this was a problem we needed to
9 solve.
10 So we've always framed it in that way, not can I
11 get a better price, can I save a few bucks. That's not the
12 point. The point is we're one of the poorest states in the
13 nation and we can't afford it, and we should be able to
14 solve this problem for our people.
15 So I said, "John, give us an offensive line." So
16 he did, and so I had just, at the time, actually, that he
17 called me I was at the NGA, which is a very fantastic
18 organization and it's bipartisan, and they have a health
19 division. And I went to NGA and said, "Hey, could you
20 convene for us a bipartisan group of governors and policy
21 experts, and also bring pharma to the table and also bring
22 payers to the table, and let's try to solve this problem."

1 And the Arnold Foundation funded that, and that
2 was very helpful because it reduced some of the political
3 heat on us, frankly, and also built a coalition of 11
4 governors and states who really wanted to solve this
5 problem with hep C. We focused not only on the area of
6 hepatitis C but also the opioid epidemic. Sadly, the
7 prices of opioid treatment are out of reach.
8 I wrote a standing order two years ago so that in
9 any pharmacy in Louisiana Dr. Gee has written you for
10 naloxone, and the first year 14 people filled it, because
11 it is so expensive. And there was great news this week
12 that there's a new generic and it's $178. And who is going
13 to go to a pharmacy just in case someone they know
14 overdoses, and pay nearly $200 just to have it? I mean,
15 this is just -- so, anyway, so we also focused on the
16 opioid epidemic, because that is also crushing states, but
17 today is not about that.
18 So we had a very fruitful number of discussions
19 about several models. In the meantime, I continued to work
20 with Peter Bach and Mark Trusheim at MIT. We looked at
21 other models for what could be done. So 1498, not a
22 possibility. What else? So the question to the

1 pharmaceutical industry and then started to become a
2 partnership with them was, okay, 1498 is a non-starter.
3 What can we do? You see our budget. You see the
4 situation. You all know, in 2014, because of the new and
5 ground-breaking drug, Sovaldi, Medicaid paid 24.3 percent
6 more for drugs. So every state was feeling the crunch.
7 But tell us how to solve this problem.
8 So the NGA process continued, and in the meantime
9 there really wasn't a lot of traction for this discussion
10 until Mavyret came out. So when AbbVie came out with a
11 competitive drug and in this space of a cure there started
12 to be some competition, then we got somewhere. So the drug
13 companies have come to the table and are very enthusiastic
14 about this. We've had public comment. We have released
15 our RFI, which you can see, responses that were very -- in
16 August, finally, after we realized that we did have some
17 will to achieve a subscription model, which then was the
18 best policy solution that was identified, which was really
19 a win-win for pharma and for Louisiana, and I think was
20 arrived at because of a number of factors. One, that there
21 was a competitive space, and so companies liked the idea of
22 -- and we can get into this later -- they liked the idea of

1 a subscription model in the area of a drug that cures,
2 because, by nature, something that cures over time has a
3 diminishing graph line. And a subscription model is flat,
4 right. So we can guarantee a number of years of guaranteed
5 spend. Drug companies get good PR, which is, of course, an
6 increasing issue in this country, the fact that prices are
7 really impacting the public's health and impacting access,
8 and the public is getting that, and so our legislators, and
9 so are states.
10 And so I think this was really a perfect solution
11 in that the companies like it because they don't lose
12 money. And our argument was, "Listen, we also need to
13 mention focus on corrections, because Louisiana is the
14 number two state in the nation, highest number of
15 incarcerated people," and we didn't want to ignore that we
16 had potentially tens of thousands in corrections and not
17 treat them, as 90 percent of them get out. And so if we
18 want to cure hep C we have to deal with corrections. So
19 that's been a part of our model.
20 So where we are now is negotiations with CMS are
21 continuing. They're very positive. The Trump
22 administration has been fantastic to work with on this.

1 The companies have publicly expressed their -- some of them
2 have publicly expressed their enthusiasm and have been
3 working with us. United Healthcare, Centene, and others
4 have publicly commented. There is a path forward, and both
5 PhRMA and Gilead mentioned in their public comment the
6 supplemental rebate program, which is a known -- of course,
7 the biggest barrier is Medicaid best price, so companies
8 don't want to enter into an agreement with a state when
9 they interfere with Medicaid best price and then impact
10 their entire national, as well as potentially global
11 markets.
12 And so we have a number of work-arounds, 340B and
13 corrections, supplemental rebates in Medicaid. We thought,
14 initially, we were going to have to do an 1115. We don't
15 believe we -- nor does CMS, has CMS indicated we need to do
16 an 1115 waiver.
17 So we are full speed ahead. We have also engaged
18 funders on the public health infrastructure and complete
19 re-imagination of how we treat hep C, because if the goal
20 is not to treat people once they're sick but to treat
21 everyone, that's a complete public health transformation,
22 and we have focused on that. We're already -- we've

1 already -- we are very close to receiving funding to do
2 that and already have a public health strategy in place and
3 have been working with federally qualified health centers.
4 What's also beautiful about this is Senator Cassidy, one of
5 our two Senators, is a hepatologist, has been supportive.
6 His nurse is going to be one of our coordinators for this
7 work, which he worked with in the charity system.
8 So we are full speed ahead. I think the policy
9 details are interesting, but I think more interesting is
10 how this came about, which was a variety, I think, of
11 messaging, politics, and then a competitive market that led
12 to companies wanting to find a new way to fund. So we're
13 very excited about the potential and how much this can
14 improve the health of our state.
15 * DR. JEFFREY: Good morning. Thank you for the
16 invitation to be here today. My name is Paul Jeffrey. I'm
17 the Director of Pharmacy for MassHealth. I've been in that
18 position for 17 years, so I have a lot of battle scars from
19 that, from being in that job, but it's been a very positive
20 experience.
21 I'm going to talk a little bit today about our
22 attempt to get a waiver from CMS from some of the

1 constraints that we felt were holding us back a bit, and
2 also talk a little bit about a way that we've decided to
3 handle new-to-market, very expensive drug therapy that's
4 administered in the hospital.
5 So just -- I won't spend more than a minute on
6 this slide. MassHealth, Massachusetts has been fortunate
7 to be, you know, able to create some health care reforms
8 over the years. In March of this year, we transitioned 1.2
9 million members in our plan into an ACO model of care,
10 which I think, among other things, stamps our commitment to
11 value-based payment structures for health care.
12 The system is relatively complex and I won't get
13 deep into it, but any member in the Medicaid program who is
14 eligible for managed care, in one stripe or another, will
15 be enrolled in an accountable care organization, or in one
16 of our remaining managed care organizations, which we have
17 shrunk dramatically since we've implemented. The balance
18 of our members typically have other insurance. So we have
19 about half a million members that have other primary
20 insurance.
21 This was launched in March. It was quite a
22 heroic effort to stand it up and then, likewise, to

1 transition all of our members into this process, and we're
2 about to go into year two starting in a few days.
3 So we requested a waiver that has been
4 essentially referred to as the closed formulary waiver, by
5 both advocates and detractors from the concept. This
6 timeline, I'll only reference the fact that when Secretary
7 Price came forward with a proclamation about HHS offering
8 flexibility in certain policy decisions at the Federal
9 Government level, we thought that that might be an
10 opportunity to suggest something that was certainly out of
11 the box. So we huddled locally, internally, and we created
12 this concept that we would like to get some relief from the
13 Medicaid governing rules in order to operate a closed
14 formulary.
15 And maybe, in retrospect, that terminology was
16 problematic. That said, we went forward with our process,
17 and we submitted our state plan amendment in draft form.
18 Once the draft form hit the phones rang off the hook, so we
19 had a lot of interest in this waiver, and spent many hours
20 talking with stakeholders about what our intent was,
21 including, of course, CMS.
22 When the President's blueprint came out and

1 offered an opportunity for an exemption from the Medicaid
2 Drug Rebate Program for five states in the demonstration
3 project we could kind of project that that was probably the
4 death knell for our waiver. All the same, you can imagine
5 the challenge of stepping out of the Medicaid Drug Rebate
6 Program. Massachusetts, last year, collected $910 million
7 of rebate, so it would not be rational, of course, to put
8 that at risk, so we certainly didn't do that.
9 Once we got the denial from CMS, we retracted
10 some of our local legislative initiatives because they were
11 hand in glove with that CMS waiver request. So we're back
12 to the drawing board, and I'll tell you a little bit about
13 what we're looking like today.
14
15 So the background is that our spend in pharmacy
16 has doubled over a very short period of time. I spent a
17 lot of time looking at the pharmaceutical pipeline. The
18 trend is expected to continue. The drugs in the pipeline
19 are alarming in terms of their cost, but sensational in
20 terms of their clinical efficacy, and the science is mind-
21 bogglingly brilliant. That said, though, how are we going
22 to accommodate that even in a state that's relatively well

1 heeled, like Massachusetts? The numbers were pretty scary.
2 So we have made best efforts to maximize our
3 rebate opportunities under the current structure. However,
4 there are some limitations to that. Some of them are
5 local. So, for example, we have to procure supplemental
6 rebates in our state system using the state procurement
7 rule that we would use for procuring other contracts or
8 bathroom fixtures, you know, so it's the same process,
9 which is exceedingly difficult from an administrative
10 burden. So we're looking for relief from that as part of
11 our local legislative package.
12 And then, of course, we don't have the ultimate
13 hammer, which would be if the manufacturers refuse to
14 negotiate, you know, if we walk away from the table, then
15 we could say you're not on the formulary any longer. And
16 that was the tool that we were looking for in the waiver.
17 Let me say at this point that it was never our
18 intent to deny access to drug therapy, never, not for a
19 minute. So, of course, convincing people of that,
20 particularly the advocacy community or stakeholders, PhRMA,
21 patient advocates, became a hard sell. But that was not
22 our intent. Our intent was to be able to negotiate a

1 value-based cost, net cost for the drug in our program.

2 So these steps one and two were locally. We
3 proposed this to our legislature, which was taken back when
4 we lost the waiver approval. So we will essentially
5 continue with this strategy to request ability to directly
6 negotiate with manufacturers in a much less burdensome
7 process without going down the rabbit hole. The
8 opportunity for supplemental rebate, just your standard
9 market access supplemental rebate in the Medicaid program,
10 dries up in about a year, just the way the market works.
11 So if we're not on top of it right away, then we're going
12 to forgo the best opportunity there because of Medicaid
13 best price and the negotiations with manufacturers in the
14 commercial market, the rebate -- you know, we get the
15 advantage of that rebate, but it's two, three, four
16 quarters later. So there's a year of opportunity lost
17 there, and we've calculated that to be not insignificant.

18 So we intend to move forward with identifying a
19 cost-effective target price. We'd like to use independent
20 third parties to help us with that. A local neighbor of
21 ours is ICER, so we've done a lot of thinking around this
22 using either ICER's work or direct discussions with ICER.

1 There are some limitations to that. It would not be the
2 only approach that we would use. The disability advocacy
3 community is not in favor at all of any kind of reference
4 pricing that uses qualities, so we're going to have to
5 accommodate that in our thought process. And, of course,
6 we would intend or envision having outcomes-based
7 arrangements as we move forward.

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

19 The third part was the CMS waiver piece, and
20 that's where we asked for the ability to determine that a
21 drug would not be on our formulary if we couldn't meet
22 agreement in our step one and two and/or, excuse the

1 terminology on the slide, no proven efficacy, it would be
2 relatively so. And we have also taken some criticism
3 around our apparent targeting of accelerated approval
4 drugs. That is not -- that is somewhat warranted, drugs
5 that are coming to market under an accelerated approval.
6 They're still approved, are FDA-approved products, but
7 reading in the product literature, you know, you can -- in
8 the product labeling you can see that efficacy is yet to be
9 demonstrated. So we want to make sure that we can bear the
10 -- have a process for bearing the cost of that over time.
11 And then we would have additional guardrails to help
12 protect our members should we engage in this kind of a
13 negotiation around formulary exclusion, which, again, now
14 is off the table and we won't be resubmitting on that.
15 So I'm going to switch with the last minute or
16 two I have to talk about a payment strategy that we have
17 embraced for new-to-market cell and gene therapy. These
18 are the -- first to market was Kymriah for acute
19 lymphoblastic leukemia in kids. It came with a guarantee
20 of performance right out of the chute, and that caught our
21 attention, of course. So did the $475,000 price tag. And
22 now there are three such products in the market, at least

1 in our categorization, Yescarta the second and Luxturna for
2 genetic blindness the third. If those drugs are
3 administered in our inpatient hospital environment, they
4 would be paid under a bundled payment, for lack of a better
5 term, based on a commercial product that was adapted in
6 Massachusetts. So we call those the inpatient payment, an
7 adjudicated payment amount per discharge.
8 In that methodology, a $475,000 drug charge
9 absolutely distorts the methodology. So running our
10 numbers, we made a determination that -- and we now have
11 some evidence of what might happen, but let me make the
12 point. We made a determination that that distorted our
13 methodology, so we wanted to carve those drugs out of the
14 methodology. So as we walked through this, there turned
15 out to be numerous benefits to doing that, not the least of
16 which is we wanted to be able to monitor these patients,
17 particularly if there was an outcome-based arrangement.
18 The Kymriah deal is with the provider, the hospital, not
19 with the payer. So we had no way to really directly
20 monitor that, nor could we comply the hospital to sign up
21 for the outcomes-based agreement.
22 So one of the things, we got a fair amount of

1 interest on this model from the pharmaceutical industry
2 because they see this as something that would allow the
3 industry to work with the payer in an outcomes-based
4 arrangement, maybe differently than with the provider,
5 which is essentially what the Kymriah deal looks like.
6 So we asked for and received through a state plan
7 amendment authority to carve these drugs out of our bundled
8 payment in both the inpatient and the outpatient setting.
9 Curiously, in the outpatient -- in the inpatient setting,
10 if the drug's carved out of a bundled payment, it makes
11 that drug a covered outpatient drug, making it eligible for
12 rebate. So that move in and of itself would ostensibly
13 save 23.1 percent for newly marketed, very costly drug
14 therapy for the Medicaid program. And that's one of the
15 reasons I think we're getting a lot of questions about
16 that, and also because of the industry's interest in ways
17 that we can negotiate arrangements around outcomes-based or
18 performance-based deals, if you will, contracts with the
19 manufacturers for these drugs.
20 So I'll stop there. I'm at my time. Thank you.
21 CHAIR THOMPSON: Great. Thank you, Dr. Gee, Dr.
22 Jeffrey. That was extremely helpful. I know a bunch of

1 Commissioners will want to jump in and ask you questions.
2 I was particularly struck by both of you talking
3 about the journey and the kinds of things that you were
4 thinking about and contemplating and the reaction from
5 pharmaceutical manufacturers, from beneficiaries, from
6 advocates, and so forth. So I think that's very helpful
7 for us to kind of take into consideration as well as we
8 think about any particular recommendations that we might
9 make to the Congress or to the administration.
10 I want to pick up on a couple of points. Dr.
11 Gee, you talked about spending some time supported by the
12 Arnold Foundation talking with a variety of other states.
13 A couple of points I wanted to ask you to expand on. One
14 is you mentioned the idea that hep C particularly, that the
15 savings associated with providing that cure are really
16 delivered to other payers, not to Medicaid. So I would
17 love for any conversation that might have been had about
18 how to recapture that value chain, like is there a way to
19 quantify that? Is there a way to capture that back if
20 Medicaid is making -- we've talked about this in this
21 Commission a couple of different times. If Medicaid is
22 making an investment when people get really sick or when

1 people can't work and they are returning to work or they
2 are coming into another payer healthier and without needing
3 some of those investments, is there a way for us to
4 quantify and think about how Medicaid can get some kind of
5 recapture?

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

12 DR. GEE: So in terms of other states and
13 capturing savings, I think part of the importance was to
14 ask for writing a new equation, right? So we can't solve
15 the discount equation, so I think part of the value of that
16 discussion was bringing states together. Our goal is a
17 population health one, which is to eliminate an infectious
18 disease. That's very different from approaching it from a
19 standpoint of what additional discount can I get, how good
20 can I do, right? A very non-transparent process. I used
21 to be on the advisory committee that approved the
22 formulary, and I wasn't even allowed to see what the price

1 was, right? So that whole -- so we're not addressing all
2 of those issues, but we're addressing the value proposition
3 for the American people, which is that the U.S. produces
4 and does the large lion's share of the intellectual
5 investment in these cures, and then the American people
6 don't get to benefit from them. So how do we solve this?
7 So I think that that was a really valuable
8 discussion, and, of course, PhRMA, I want to highlight how
9 engaged they were and how helpful they have been. So all
10 three companies that produce these drugs were engaged, have
11 been supportive, and have been at the table, which I think
12 was very important to our being able to get to the point
13 that we are now.
14 So in terms of long-term savings, we have
15 certainly talked with CMMI, had great conversations with
16 Adam Boehler and others about Medicare savings down the
17 road and how you could leverage that. I certainly think
18 that that's applicable in other areas. This is such a
19 large problem for us that we have 100,000 people nearly on
20 our registry. We think probably the number is 200,000.
21 We're looking at dealing with corrections. And so the
22 number, if you looked at -- but when we look at a year

1 savings for Medicaid, so Peter Bach's Abacus tells us that
2 looking at our own Medicaid claims data that only about
3 $600 a year would be saved by the treatment. So if you
4 look at churn and how long people stay in Medicaid and so
5 on, you know, that value proposition may not be there. So
6 we've had discussions, but this is a daunting -- you know,
7 there's so many people. I think that conversation's
8 probably more applicable to conditions that are more rare.
9 And I think it's an important one to have, a very valuable
10 discussion to have. And we certainly also even thought
11 about veterans, right? So we have lots of incarcerated
12 veterans. Wouldn't Veterans Affairs have an interest in us
13 treating incarcerated veterans with hep C because they'll
14 save money down the road?
15 So I think these are really important
16 discussions, but there was no quick fix at CMMI, and we
17 have both -- we have lots of pressures. I think one of
18 them is that PhRMA's willing to come to table and has
19 publicly expressed enthusiasm. So we don't want to lose
20 that momentum. And so these conversations are important
21 and will continue to happen, but we decided not to go that
22 route.

1 In terms of best price, there are a variety of
2 work-arounds. I'm not a pharmaceutical pricing expert, so
3 I don't know if I can give you an answer. What I can say
4 is that I think that our recommendations from the National
5 Academy of Medicine Affordable Drug Study were very
6 powerful. Very few, if any, have been implemented really
7 at a systemic level. I think we should start there.
8 Really, if something doesn't work or doesn't provide value,
9 I ought to not have to pay for it. I think we had a look
10 at subscription models -- you know, we ought to promote the
11 pharmaceutical industry looking for cures because,
12 unfortunately, the economic model for a cure is not in the
13 long term very good, and so I think the subscription model
14 is a way, an interesting way to look at how you can sustain
15 and have a predictable income from those medications.
16 I do think, you know, certainly the 340B program,
17 which you're going to be talking about later, is a work-
18 around. Supplemental rebates are a work-around. So we
19 have work-arounds to best price. The issue is that the
20 drug companies typically are not motivated to use those
21 work-arounds or, you know, certainly not at a population
22 level, and I think if we are able to use this in

1 corrections, this would be, to my knowledge, in terms of
2 hep C, the first state to really look at the entire
3 correctional population and treating them. The idea of
4 this is to take the spend we have, because the other
5 argument is we're not going to have more money. Louisiana
6 is not going to come up with another $200 million, and so
7 why do you care, pharmaceutical industry, if we treat
8 everybody -- we do have an opioid epidemic that I didn't
9 mention, so we've seen a great increase in the number of
10 hep C, so this condition will be alive and well for a
11 minute, and so let's not worry about, you know, the meta
12 goal, which is complete cure on the face of the Earth. So
13 there should be ongoing profit. But let's solve a problem
14 now, and I do think certainly best price was a substantial
15 impediment and early on seemed near insurmountable, and we
16 do go to CMS and say can we waive it, and they said no,
17 just can't waive it. So I do think that that is an
18 important consideration for you all.
19 CHAIR THOMPSON: Thank you very much.
20 Dr. Jeffrey, the question I wanted to ask you was
21 kind of building on your point about not wanting to put the
22 entire savings associated with the Medicaid rebate program

1 at risk. Is there -- which I think is right. Most states
2 are not going to be willing or able to do that. Even if
3 they think they have a set of creative ideas or some
4 alternatives, that's a lot to place at risk.
5 Is there a percentage of that that could be
6 placed at risk? In other words, if you contemplated a
7 situation in which you were granted more flexibility for
8 maybe some smaller percentage of rebate, is there some room
9 in there between all or nothing to be able to have some
10 maneuvering room that you would want to exercise that you
11 would be willing to accept?
12 DR. JEFFREY: So thank you for the question. I'm
13 not sure how I'd structure -- or how we would structure
14 such a thing, but we would want to be open to any
15 alternative arrangement that we would think would be to the
16 best benefit of the commonwealth. I'm not sure how I would
17 see that occurring. So I'd like to -- you know, the wheels
18 aren't putting together a model here yet. So, yeah, we
19 would put -- we would obviously be willing to put something
20 at risk if the return on that investment would be in the
21 best interest of our members and the state. So the answer
22 would be yes, but what proportion or how we would make that

1 look, I really haven't conceived of that.

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

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

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

18 CHAIR THOMPSON: Okay. Stacey?

19 VICE CHAIR LAMPKIN: Thank you both. This is
20 fascinating. We've been talking a lot about managed care
21 service delivery models and oversight of those models, and
22 I'm curious. I would like to hear how you are

1 incorporating these pricing innovations into your managed
2 care programs or not. Have you carved out the hep C drugs
3 so that you can run the subscription program? How are you
4 thinking about this in that service delivery model?
5 DR. GEE: Sure. So we thought about a variety of
6 ways and the comments, the response to our RFI suggested a
7 variety of ways, but -- and at some point, managed care
8 companies came to us and said, "We'd like to do our own
9 subscription model. What do you think?" Our concern of
10 that is if you break it up into too many segments, the
11 companies are just not going to be motivated. What's
12 motivational to these companies is they get a large
13 population, they get a sustained income, and it shouldn't
14 be much of a decrease, or maybe a slight increase over
15 their market share. So I think that -- you know, I think
16 that's a really important point.
17 So in terms of managed care, you also don't want
18 -- people with hep C have lots of other conditions that are
19 important to treat. They have mental health issues, so
20 totally carving out the person didn't seem to make a lot of
21 sense. So where we are now is to think about carving out
22 the spend just for hep C drugs, and that seems to be the

1 most plausible.

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

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

22 It's likely that the better arrangement in terms

1 of clarity of what the state's purpose is and how
2 prescribers should respond or providers should respond to
3 our intent to have a universal policy. But today we're
4 doing that on a therapeutic class basis. So if we enter
5 into a -- however, let me talk about the carve-out for --
6 we have not imposed that requirement on our accountable
7 care organizations or our managed care organizations to do
8 the same. So the way we would -- the lever we would use is
9 in risk corridors or exceptions from the total cost of care
10 calculation. So our hepatitis C drugs are carved out, so -
11 - virtually. The managed care organizations still manage
12 it, but there's a separate financial accounting for that.
13 CHAIR THOMPSON: Maybe it's a little bit of the
14 same thread, although in a different direction. One of the
15 other things that we've talked about in this Commission is
16 the way in which Medicaid compares to commercial payers in
17 terms of how purchasing happens, how oversight happens, how
18 utilization review happens, how management controls are
19 deployed.
20 So could each one of you talk a little bit about
21 the extent to which you engaged in conversations with other
22 payers in your state or region around some of what they're

1 doing? I'm struck by both some of the conversation around
2 you need to have a certain amount -- and we've talked about
3 this before, too, even in terms of purchasing pools -- how
4 much volume do you have to have and do you have to deliver
5 to a manufacturer in order to get the concessions that
6 you're looking for and create the kind of partnership that
7 you're looking for. So I'm just wondering where the
8 commercial payers may have played in the conversation in
9 terms of either lining up or aligning or coordinating or
10 not being a part.
11 Dr. Gee, could you start off?
12 DR. GEE: Sure. This is not answering your
13 question, but a point I think is important to make, is one
14 approach we could have taken is to go with a company to
15 CMS, right, the waiver to the agreement.
16 What we are envisioning, which I didn't describe,
17 is a transparent competitive process. So either RFI,
18 respond to RFP response, which should be -- we envision
19 depending on our process in terms of our division of
20 administration and RFP approvals to go ahead in the next
21 month. So that is, I think, the best way. I think it's
22 best for us. It's best in terms of the companies and the

1 timeline that we were looking to achieve.

2 CHAIR THOMPSON: Thank you for that verification.

3 Thank you.

4 DR. GEE: So then in terms of the private -- so

5 one of the first conversations we have, so Louisiana is a

6 predominant Blue Cross Blue Shield market. We have a great

7 relationship. They also oversee one of our Medicaid health

8 -- or have a relationship with one of our Medicaid health

9 plans, an interest in it, and so went to them and said --

10 and others have envisioned if you really want to eliminate

11 hep C, surely you would want the entire population of

12 Louisiana in a model and a population health model.

13 So a couple things. One is Blue Cross had looked

14 at their own data and said, "We don't think we have as big

15 a problem as you do." I mean, our problem is really in

16 corrections. We treated about 0.5 percent of people in

17 corrections last year or maybe fewer, probably fewer. In

18 Medicaid, we treated about 3 percent of people. So we are

19 not nearly where we need to be.

20 Blue Cross looked at their data and said, "When

21 we look at the time trend of number of people treated

22 getting in, we don't think we have as big a problem. We

1 can accommodate," and certainly, they can raise their
2 rates, right? So if the costs go up, they can raise their
3 prices. We can't. They've been able to accommodate in
4 ways that we haven't, and we also were concerned that
5 bringing in Blue Cross into the discussion would be jarring
6 to the pharmaceutical industry and threaten their
7 relationships across the nation. What we're really trying
8 to do is get a workable solution as soon as possible and
9 didn't feel that bringing Blue Cross along was necessary.
10 There's been a lot of interest. Other states
11 have private insurance markets call, I have had calls from
12 North Carolina and so on saying can we learn from this. I
13 don't know that it's as compelling.
14 And also, just to reinforce, although there is an
15 opioid crisis and the rates are going up, the population of
16 people that have hepatitis C tends to be lower income, very
17 high corrections reservoir of people who are infected. So
18 it's a little bit different problem and higher barriers for
19 Medicaid agencies than for a Blue Cross Blue Shield.
20 DR. JEFFREY: I'm not aware of any formal
21 conversations with our commercial payers in Massachusetts.
22 They likely occur on an informal basis, if you will.

1 However, all of our managed care organizations
2 today have commercial lines of business. When we discuss
3 matters related to pharmacy policy, just on my level, at
4 the director pharmacy level, I'll get a reflection of
5 "Well, we can do this for the managed Medicaid plan, but I
6 have to take some consideration for what that means to my
7 commercial population."
8 Let me also make reference to the fact that there
9 are some efforts to put the commercial payers and the
10 Medicaid program together. They are at the talking stage
11 now through a program at MIT. You may be familiar with
12 their NEWDIGS FoCUS program, but it's a think-and-do tank
13 to try to create solutions to high cost or high-investment
14 medications. And there's a proposal to have an outcomes
15 milestone-based arrangement that would include a group of
16 commercial payers, and they're trying to get the Medicaid
17 program involved in that process.
18 You asked about utilization. Utilization to me
19 is an entirely different story in the Medicaid population.
20 We do not have the levers that the commercial plans have in
21 terms of essentially co-opting the members in the process
22 by out-of-pocket expenditures. So a commercial payer will

1 leverage the utilization of pharmaceuticals based on co-
2 insurance, copays, and things of that nature that we have
3 no access to. We do have nominal copays in Massachusetts,
4 but less than half of our members actually pay a copay
5 because they're exempt in some way or another, and the
6 maximum copay is $3.65. So that becomes important to a
7 Mass Health member who has 12 medications a month; however,
8 unlike a commercial plan, I'm not going to be looking at
9 $100 copay for a brand-name drug and ask my doctor to
10 prescribe me a lower-cost copay drug. That's not going to
11 happen in the Medicaid program.
12 We use a lot of prior authorization in the
13 Medicaid program for pharmacy, a lot. We're not always
14 very popular with the prescribers, as you might imagine.
15 DR. GEE: Just one additional point, we
16 considered the uninsured population in Louisiana. Of
17 course, the Medicaid expansion has reduced that
18 dramatically, but the irony is often uninsured people are
19 better off when they have hep C because there are patient
20 assistance programs that make the drug affordable. If
21 you're incarcerated or on Medicaid, those programs are not
22 available.

1 So although we care about folks who are
2 uninsured, we really focus on getting people covered, and
3 patient assistance programs is our solution for them.
4 CHAIR THOMPSON: Thank you.
5 So just reflecting on some of the things that you
6 found to be easier, harder, possible, impossible in terms
7 of thinking about the federal statute, any advice to us
8 about places where we should be looking hard at
9 recommendations around changes to Title XIX, to the rebate
10 program and the way that it operates, the flexibility that
11 states have, the places where we should be looking to carve
12 out or change or make refinements, so that you can adopt
13 some of the practices that you're looking at?
14 DR. JEFFREY: Let me just get this out, off my
15 head, about tinkering with the rebate program.
16 The pharmaceutical industry in this country is
17 anchored in a rebate-based method of payment. The average
18 payment by a payer in the United States is at 52 percent of
19 the list price of the drug. So we are playing with more
20 than 50 percent of the money that's moving around here in a
21 discounted program through a rebate structure.
22 I would be cautious about which levers get pulled

1 there and what the unintended consequences of that are, and
2 I think that pharma is likely to win, no matter what the
3 model looks like, unless we impose some kind of price
4 controls. I'm not advocating for that; however, if there
5 isn't that limitation, then what's to stop the
6 pharmaceutical industry from charging the cost, the price
7 that they want, one way or the other?
8 Of course, all the rebates are baked into the
9 launch price, as you well know. Just a cautionary tale
10 there from my perspective.
11 CHAIR THOMPSON: And so your point, Dr. Jeffrey,
12 there is simply that you can move a number, but it's going
13 to get made up on this other end?
14 DR. JEFFREY: Absolutely, absolutely.
15 I think that there's opportunity. I don't know
16 that it will bend the cost curve, but I think that states
17 need greater latitude and flexibility in crafting outcomes-
18 based arrangements.
19 We do have a green light from CMS to engage in
20 such arrangements today. I think that some support in
21 terms of what we determine the value of medications is from
22 the federal level would be very useful. I know that that's

1 a third rail, but just saying.

2 CHAIR THOMPSON: While we're spit-balling.

3 DR. JEFFREY: Yes, exactly.

4 [Laughter.]

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

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

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

14 We found a work-around, we believe. Right now,
15 we don't think that the federal structure in terms of best
16 price is an impediment to us, but I do want to suggest that
17 we need a greater focus. And I think a great example of a
18 work-around that's benefitted the public, to a great
19 extent, is the Vaccines for Children program because that's
20 an area where access was a problem, and we have a new way
21 of delivery that's been very successful in Louisiana. It's
22 one of the few things we do great on in terms of public

1 health is getting kids vaccines. I would suggest that you
2 all should focus in these areas.
3 There are areas, the access to prep, HIV
4 treatment, hep C, treatment for opioids. We can't afford
5 it in Louisiana; for example, methadone. And we can't
6 afford to get naloxone in the hands of first responders
7 because of price. We can't afford to eliminate hep C. So
8 I would suggest that we don't get in the way.
9 We also don't want to disincentivize cures.
10 Sovaldi was a fabulous thing that gave many people hope.
11 It's a tremendous innovation. I've been very thoughtful,
12 as we've gone on this journey, not to try to disincentivize
13 future cures. That's not what we want to do. So how do we
14 solve these problems in a way that's a win-win, but makes
15 sure that the people of this country have access to cures
16 and we can solve public health challenges?
17 And there is real brokenness there. There's
18 brokenness in terms of the research that gets done, because
19 we don't do research in areas that aren't lucrative --
20 sickle cell disease, contraceptives, vaccines even. The
21 Zika vaccine got dropped by Sanofi because a variety of
22 reasons, but that's disappointing because it's coming back

1 in Brazil. And it may come to me next. So we've got to
2 have -- I think there is an interest for more governmental
3 role, greater governmental role in areas that are really
4 important to public health, where the public suffers and/or
5 costs go up.
6 There's a lot of anger in this country about
7 health care costs, and in my state, a lot of the anger is
8 directed at the recipient, the people, the fraud, "The
9 individuals who have Medicaid, by darn, and they don't
10 deserve it, and let's get them off," instead of really
11 where we ought to focus is, Why in the hell is health care
12 so expensive, and what are we doing about it? And why
13 can't we afford -- why are we paying so much for things the
14 taxpayer has to pay for?
15 In the area of Blue Cross, they can raise their
16 rates, and unfortunately, individuals have to pay for it.
17 The rates go up; the taxpayers of Louisiana have to pay for
18 it. so I think that those are areas where there's
19 population health interests that you all ought to be
20 involved in. We absolutely need intervention, I believe,
21 but I cannot be at the death of innovation. And those are
22 important conversations.

1 What I don't like about the pharma argument is
2 "You take a dime from me and innovation comes to a halt,
3 and it just completely stops." That's ridiculous. But
4 there are important arguments that they make that we have
5 to be conscious of.
6 DR. JEFFREY: May I make one -- a couple things
7 jumped into my mind.
8 CHAIR THOMPSON: Absolutely. Yes.
9 DR. JEFFREY: One is I have some concern about
10 accelerated-approval drugs that come to market for which
11 the total proof of efficacy is lacking; however, they do
12 get approved.
13 My concern is that not every manufacturer
14 completes the requirements for demonstrated efficacy of
15 those drugs. So the performance on post-marketing
16 surveillance to fully flesh out the label is poor, maybe in
17 the 50 percent ball park.
18 I think the one thing you might contemplate is
19 making an arrangement or allowing an arrangement where
20 manufacturers are held accountable to Medicaid programs
21 relative to maybe an enhanced rebate during the period of
22 time until they demonstrate efficacy or a penalty if they

1 don't, something to that nature.

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

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

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

1 truly million-dollar drug.

2 CHAIR THOMPSON: Thank you.

3 Let me just take a look and see if any of the

4 other Commissioners -- Peter.

5 COMMISSIONER SZILAGYI: This is really excellent.

6 Thank you.

7 Dr. Gee, could you just explain the subscription

8 model? I think I'm missing -- are you promising that a

9 higher percentage of patients were going to get the

10 medicine for a lower cost? Is that sort of the bargain, or

11 can you describe that?

12 DR. GEE: Yeah. The idea is that we take our

13 spend now, and we do an RFI or RFP and say, "Hey, company,

14 we spent X." Let's say it's $35 million. "We'll give you

15 that or less, and we get unlimited access." And so the

16 company is guaranteed to get that, and then at a certain

17 point, we get 100 percent rebate after we go over that. So

18 that's the idea.

19 And then in corrections, it's a different

20 process. The correctional -- what we have in Louisiana in

21 corrections is a relationship between the 340B entity and

22 the correctional facility, and so it's a little more --

1 you're not talking about the -- in 340B, you don't run into
2 best price issues, and so then you're able to come up with
3 an overall price and that correction spends. And so the
4 idea is don't increase our spend that we have now, but get
5 near unlimited access.

6 CHAIR THOMPSON: Darin.

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

20 Help me, on the Massachusetts side, understand.
21 I see that you'll have third-party independent analysis.
22 You'll have this, and then you talk about negotiating with

1 them. Does that come in the form of a special supplemental
2 rebate? How are you coming back to the value in which your
3 third party is calculated?
4 DR. JEFFREY: Thank you.
5 Maybe an exemplar would work. So drug A costs
6 the manufacturer's wholesale acquisition cost is $400,000
7 per treatment for a year, something like that.
8 Using internal processes as well as external
9 parties, let's say ICER and perhaps some other threshold,
10 value-based evidence, value-based model, we calculate that
11 that drug really should be priced at $200,000.
12 So we go to the manufacturer and we say to the
13 manufacturer, "If you want access to our formulary and
14 we've been negotiating what the terms of that looks like,
15 what does the pharmacy benefit look like there, we believe
16 the price should be $100,000 -- I'm sorry -- $200,000. You
17 need to commit to us 50 percent rebate." And that's the
18 point of jumping off for the negotiation.
19 Let's say in that model, we take that to
20 fruition. We still are going to be obligated to cover that
21 drug under the covered outpatient drug rule and the
22 Medicaid drug rebate program. However, we would then take

1 a step to refer that manufacturer to a deliberative body
2 for the purposes of examination of their pricing strategy,
3 and we would make that a public process, justify why you do
4 that. You've seen this in other states.
5 Ultimately, if we follow the strategy that we
6 proposed last year, if the manufacturer fails to meet our
7 threshold pricing, they could be subjected to penalties,
8 statutory penalties that would be issued by the Attorney
9 General, for example, "This drug should be $200,000. You
10 have an unfair business practice. I'm going to fine you
11 $200,000 for every patient that gets this drug." Again,
12 hypothetically and wildly. It will not be anywhere near as
13 easy as it took me those three minutes to explain.
14 COMMISSIONER GORDON: No. Thank you. That was
15 very helpful in just conceptualizing how those models will
16 work.
17 One other question, and you talked about how
18 sometimes when these drugs are going through the FDA, the
19 efficacy, the evidence behind the efficacy is not as
20 developed, I guess, when they're in the fast-track path.
21 But even if there's situations like when we saw this with
22 hep C, where the evidence that was submitted to FDA showed

1 effectiveness at a certain fibrosis score, yet when it went
2 to market, there was the encouragement for coverage beyond
3 what evidence was submitted to FDA.
4 How do both of you all -- when you think about
5 these high-cost therapies, how often do you track back to -
6 - and do you feel you have sufficient time to track back
7 to, as you set up your criteria, coverage criteria, the
8 evidence that was submitted as part of the FDA approval?
9 DR. JEFFREY: So as we go through our process of
10 determining how we're going to manage the drug, of course,
11 we do a -- well, not of course -- we do a very
12 comprehensive review of the literature as well as what the
13 labeling says. And there are many examples of accelerated-
14 approval drugs, as you described. I could name three or
15 four off the top of my head. So we may make a
16 determination that we would manage the drug to label, or we
17 may manage the drug to the clinical trial evidence that got
18 to the label.
19 So Radicava for ALS, you know, was demonstrated
20 in the clinical trials to be effective in a particular
21 population of patients. The label came out and said that
22 any patient with ALS should have access to Radicava. So we

1 make a determination of whether we would want to manage
2 that drug to label -- anybody with ALS has access to it as
3 soon as they demonstrate the criteria that they have ALS --
4 or we could get refined and go down to the specifics of
5 what the clinical trial data. And that's a drug-by-drug
6 decision process.
7 DR. GEE: So, Darin, you've been to my office and
8 you've seen our Medicaid staff. We may have four full-time
9 pharmacy staff, okay. So what Paul has in Massachusetts,
10 he has the University of Massachusetts, he has more smart
11 people he can shake a stick at. Not that we don't have
12 smart people. We don't have lots of policy experts,
13 particularly in the pharmaceutical sector.
14 So we don't do that. We have a supplemental
15 rebate vendor. As I mentioned, even as secretary I often
16 don't get access. I'm allowed to see it but the committee
17 that decides whether something is of value can't even see
18 what the price is they're supposed to be agreeing on. It's
19 not a system that's reflexive, and certainly our hep C
20 work, from the very outset we are hopeful to obtain funding
21 to have Rena Conti and Jon Gruber evaluate our process, and
22 we're being very thoughtful.

1 I would correct maybe what you said about our
2 value proposition. We're not actually litigating the issue
3 of the value of this drug. We're saying this is what we
4 can afford and that's it. So it's a little different.
5 COMMISSIONER GORDON: [Speaking off microphone.]
6 DR. GEE: So it's a little different.
7 COMMISSIONER GORDON: Purely on the cost.
8 DR. GEE: Yeah. Yeah. But we don't have the
9 resources to go look at was this value or not. I think
10 that's something that might be of interest to you all, to
11 think about how you can help states measure value and
12 effectiveness, and we don't even look back at what the
13 percentage of care was. Certainly if we entered into a
14 value-based rebate agreement, or so on, we would want to
15 look at that. Oklahoma is there in some ways, but we're
16 really very nascent in those discussions.
17 COMMISSIONER GORDON: [Speaking off microphone] -
18 - is what I'm saying, from a cost perspective, determining
19 what the Medicaid entity is currently spending on that
20 population, and that being a determining factor for the
21 pricing of that particular agent.
22 DR. GEE: But we're not saying that they're not

1 the value of the company. Maybe they are the value of the
2 company. But our point is we can't afford that value.
3 CHAIR THOMPSON: Okay. Let me go for one more
4 round, making sure I'm not missing anyone. Dr. Jeffrey,
5 Dr. Gee, thank you very much for being patient with us and
6 letting us keep you past your time. We could probably keep
7 you here for quite a bit more, but we'll call a halt at
8 least to this part of the conversation.
9 What we're going to do, just because we're a
10 little bit behind time, I'm going to go ahead and call a
11 break now. We'll come back in 15 minutes, at 11:00. We'll
12 take public comment before we begin our discussion, so that
13 if any members of the public want to add to the points that
14 have been made by our panelists, or respond to any of the
15 lines of questions that we've had here, as Commissioners,
16 you'll have an opportunity to do that. Then we'll have a
17 little bit of a Commissioner conversation before moving on
18 to other topics.
19 Dr. Gee, Dr. Jeffrey, thank you very much. This
20 has been extremely useful. We really appreciate you taking
21 time out to spend some time this morning with us.
22 DR. JEFFREY: Thank you for the opportunity to be

1 here. We appreciate it.

2 [Applause.]

3 * [Recess.]

4 CHAIR THOMPSON: All right. I'll give the 15-

5 second warning here for wrapping up conversations, and then

6 we'll turn to our discussion period.

7 [Pause.]

8 CHAIR THOMPSON: All right. First let me invite,

9 as I promised before the break, an opportunity for any

10 public comments.

11 ### **PUBLIC COMMENT**

12 * [No response.]

13 CHAIR THOMPSON: That was a good fake there.

14 [Laughter.]

15 CHAIR THOMPSON: Okay. All right. Chris, I'm

16 wondering, to just get us started for this part of the

17 conversation, if you could remind the Commissioners and the

18 public where we are with some different pieces of work that

19 are in progress around prescription drugs so that we can

20 also keep that in mind.

21 ### **FURTHER DISCUSSION OF STATE INNOVATIONS IN DRUG**

22 **PRICING**

1 * MR. PARK: Sure. So last year we had discussed
2 some very technical changes to the rebate program in terms
3 of misclassification and things like that. That was
4 recently taken up in a House bill that they voted on, so,
5 you know, some of those recommendations have been
6 considered by the Congress.
7 This year, we started down the path to try to
8 look at how states' utilization management tools compare to
9 other payers, so last month, we presented the first round
10 of analysis that we've done comparing Medicaid's coverage
11 of drugs and their use of utilization management tools to
12 other payers and, you know, broadly speaking, for a lot of
13 drugs Medicaid seems to cover more drugs, but they also
14 seem to use more utilization management tools, and that
15 might be an outcome of them having to cover pretty much all
16 drugs. So they, you know, prior auth. or put some other
17 restrictions on it that way.
18 We also in September had discussed additional
19 changes to the rebate program such as, as Dr. Jeffrey had
20 mentioned, on the accelerated approval drugs, you know,
21 could there be some kind of penalty or higher rebate or
22 some other --

1 CHAIR THOMPSON: Which the Commission was not
2 enamored with.
3 MR. PARK: Right.
4 CHAIR THOMPSON: Yes.
5 MR. PARK: Yes. So, you know, we've had
6 discussions around that. We had other discussions of
7 trying to kind of incentivize more value-based payment
8 through changes to federal policy, as well as we discussed
9 what we've been referring to as a grace period, which would
10 give states some opportunity, like 90 days or a 180-day
11 period, to kind of evaluate all the criteria, the FDA
12 approval material, any research or statements made from the
13 professional societies, the specialists, kind of what
14 appropriate treatment patterns might be, what should be the
15 prescription guidelines so that they would have some time
16 to kind of consider all that to develop their criteria of
17 coverage before they absolutely have to cover a drug. So
18 this would kind of formalize a grace period for that.
19 The Commission did show interest in that
20 particular option. We've been talking to CBO about the
21 score on that. You know, we can come back to you once we
22 get that score. We also discussed removing the cap on

1 rebates, which right now the cap is at 100 percent of
2 average manufacturer price, and, you know, several drugs
3 can go over that cap, and so there's maybe an incentive,
4 once you hit that cap, to just keep raising prices. So if
5 we took that cap away, not only would there be some benefit
6 to the Medicaid program in higher rebates, but it could
7 also have benefits to other payers because it might create
8 incentives for the manufacturer to kind of slow the growth
9 of drug prices.
10 CHAIR THOMPSON: Okay. So as of now, we kind of
11 have two things that are pending that the Commission -- in
12 terms of potential recommendations that the Commission has
13 generally responded favorably to the grace period and then
14 lifting the cap, right?
15 MR. PARK: That's correct.
16 CHAIR THOMPSON: Okay. I think that that's a
17 helpful reminder.
18 So I'll open it up for the Commissioners to
19 discuss about any additional concepts or ideas that we
20 should pursue. I'll just throw one out in that. It seems
21 to me that we have the situation where when we started
22 going down the road of looking at prescription drug

1 pricing, we said to ourselves let's start to look at this
2 through a couple of different angles. We're not looking to
3 necessarily, especially initially, blow up the entire
4 Medicaid drug rebate program, and I think the more that
5 we've had conversations around that, the more that I think
6 that's correct, that was the correct path to take, and it
7 may not be that we want to be in the process of redesigning
8 the entire purchasing approach for Title XIX.
9 I do think that we continue to come back to this
10 issue that there are certain classes of drugs, certain
11 types of drugs, certain -- it may be by virtue of their
12 expense. It might be by virtue of what they do or the
13 population that they are addressing, that we may need to
14 trigger out of the traditional rebate program and into
15 something else. And I don't know if that "into something
16 else" is a regional pull, is a different economic model, is
17 flexibility for states, is -- you know, that still has
18 guardrails that give us assurance that beneficiaries are
19 going to get the therapies they need, but create a
20 different kind of economic model that make it more possible
21 for states to deliver that.
22 That is a tall order, but it seems to me that

1 that's where it would be most useful for us to spend our
2 time. And you see me coming back to, you know, wanting to
3 find a way to recognize the savings that Medicaid is
4 delivering to the American health care system, to other
5 payers, to the American economy in some way, given the fact
6 that Medicaid is going to, by its nature, by the fact that
7 less healthy people are in Medicaid, lower-income people
8 are in Medicaid, et cetera, that Medicaid is going to bear
9 the burden of a lot of costs for a lot of people who have
10 big needs, and that serving those needs allows those
11 individuals to gain employment, to be productive members of
12 society, to contribute in all sorts of ways, to ultimately
13 maybe even leave the program and be covered by other payers
14 who will not face those costs as a result of Medicaid's
15 investment. It seems to me that some kind of approach to
16 estimating and contributing to that investment would be
17 helpful.
18 So let's see. Kit wanted to say something, then
19 Alan, then Fred.
20 COMMISSIONER GORTON: So I will align myself with
21 your restatement that blowing up the rebate program doesn't
22 seem like a good thing to do. There's just too much that's

1 built around it, and Dr. Gee talked about whack-a-mole and
2 Dr. Jeffrey had a somewhat more cynical framing that PhRMA
3 would win in the end, anyway. And I agree with your focus
4 and with Dr. Gee's emphasis that it really ought to be how
5 do we get -- you know, how do we get drugs to people who
6 will benefit from them?
7 I do think there's a program integrity component
8 of how do we not give drugs and spend limited funds for
9 people who will not benefit from them. And so I don't know
10 how to necessarily square that circle, although what I
11 would say is we've had a number of people, including
12 today's panelists, who have said, you know, we think we can
13 figure out a way to work around best price. And I wonder
14 if there shouldn't be a more formal mechanism -- I mean, I
15 think the rebate system works for 95 percent of the stuff,
16 right? It doesn't work for really expensive things. It
17 doesn't work -- particularly really expensive things
18 affecting big populations. It doesn't work for inpatient
19 injectibles because, you know, they're not part of the
20 program.
21 So I would be interested in figuring out whether
22 the Commission could come up with policy recommendations

1 around tweaking best price so that it stays in place for
2 the 95 or 98 percent of things that it's working okay for,
3 but so that if a state were to enter into a value-based
4 arrangement, that we would just say, you know, okay, that
5 money is excluded from best price, that's not an element of
6 the calculation of Medicaid best price.
7 So that if somebody wanted to negotiate a
8 supplemental rebate for a very expensive drug for very ill
9 children, that somehow the manufacturer could do that
10 without triggering that best price trigger that seems to
11 hold people back.
12 So I just wonder -- and maybe Chris has some
13 ideas about this -- whether there's one or two or three
14 little carve-out, waiver, or safe harbor kind of provisions
15 that we could offer with respect to best price that just
16 might level the playing field a little bit and keep us in a
17 place where drugs are affordable to the public payers and
18 their managed care partners.
19 The other thing I just wanted to sort of note
20 here -- and I thought Dr. Gee did a wonderful job of
21 pointing to the fungibility of the beneficiaries of the
22 program, right? So they go into the workforce, they go

1 into Medicare, they go into prison, they come out of
2 prison, right? So she didn't say one of the benefits of
3 treating people in prison is that at least in states that
4 have done Medicaid expansions, when they come out of prison
5 they go into Medicaid. And so in Massachusetts, we put a
6 fair amount of energy into that particular transition
7 because if the state started paying for a course of therapy
8 for hepatitis C, then we don't want it to get interrupted -
9 - you don't want to keep them incarcerated just to finish
10 their course of therapy, and you don't want to not start a
11 course of therapy that they should have started because
12 they might get out soon. So there's -- that whole
13 transition is interesting and different in states that have
14 expanded from states that have not.
15 But I do think that you've put your finger on
16 something, Penny, in terms of -- and Dr. Gee I think very
17 elegantly framed it in terms of the public health element
18 that Medicaid plays here. And maybe the answer is not to
19 try and avoid it or try to spread the cost out, do some
20 complex cost allocation, but merely to acknowledge, and
21 maybe what we should think about is having Congress
22 acknowledge in Title XIX somewhere that Medicaid, in fact,

1 plays an important population health role and an important
2 public health role, and that in some way expenditures in
3 those ways, you know, they're matchable and people should
4 get credit -- the state should get credit for the
5 investments that they make in that.
6 So, anyway, that's a lot of maybe if, kind of,
7 sort of, and nothing very clear, but I do think that we
8 might be able to point out a couple of avenues of policy
9 that would just create a little more breathing room for the
10 states and for PhRMA and the provider community.
11 CHAIR THOMPSON: Thank you. Alan?
12 COMMISSIONER WEIL: Well, if there's one
13 conclusion I reach from serving on the National Academy's
14 Committee on Affordable Drugs, it's that dollar flows in
15 the pharmaceutical sector make supplemental payments look
16 simple, so, staff, I mean, really, I don't know why you
17 haven't figured supplementals out yet given how much higher
18 the bar is here.
19 I want to try to take these two comments and be a
20 little more precise. I appreciate the comment of not
21 blowing up the rebate system, but there is a lot of talk
22 about having some significant debate at a national level

1 about drug pricing in the coming Congress given comments
2 from the President, change in leadership. I think it would
3 be a huge mistake for us to be absent from those. Much of
4 what Medicaid is dealing -- Medicaid cannot do alone what
5 needs to be done. We may not all agree on what needs to be
6 done, but we can certainly agree it can't do it alone. And
7 so I think along the lines of things we have done on other
8 kinds of policy initiatives, being aware of the evolving
9 federal debate which will have potentially tremendous
10 consequence for Medicaid as a program and Medicaid
11 beneficiaries, we should be a part of that. And I would,
12 of course, also being a member of the National Academy's
13 group, would say that where there are opportunities to
14 actually support changes that would be positive for the
15 whole affordability and availability, where appropriate, to
16 have a Medicaid voice supporting that I think is important.
17 So I don't want us to shy away from the big stuff given the
18 potential of that discussion occurring.
19 I think the micro changes around categorization,
20 newly approved, you know, we should keep doing that. I
21 don't have any question. But I guess what I would wonder -
22 - and I think this is where I'm trying to follow on the

1 last two comments. The two things we heard, they're
2 phenomenal, and they come from phenomenal leadership, as
3 great ideas always do, and tenacity. There's actually a
4 lot else going on out there that's -- I'd call it a notch
5 below in terms of how transformative the state efforts are
6 trying to be, still very important, very difficult. These
7 are, I would consider sort of from my look at it, the
8 highest level. And I think us trying to focus on, given
9 that this issue is not only not going away but is certainly
10 going to get worse with new therapeutics that are more
11 expensive, that us trying to spend a little more time in
12 that middle segment of what is needed for states to be able
13 to experiment -- these are not success stories. These are
14 interesting ideas. We need more of them. And I think we
15 ought to really think as a Commission about -- and hear
16 from states and hear from industry about what it takes to
17 create more room for this kind of creativity, because we're
18 not ready to say, you know, Louisiana figured it out, we
19 should do it nationally. Absolutely not. And I think the
20 mixed feelings, the reaction to the proposal in
21 Massachusetts is also a sign of how fraught these issues
22 are. But we've got to create the space for that or else

1 this is -- or the alternative universe is really grim.
2 CHAIR THOMPSON: Yeah, and I don't -- when I say
3 not blow up the rebate program, meaning that what we keep
4 hearing is that there are situations and classes and issues
5 that the rebate -- the constraints of the program, the deal
6 of the program doesn't serve well. And we ought to be
7 focused on those situations, and maybe there's a different
8 system that applies there and a different, again, trigger
9 into a different world, whether that world is flexibility
10 or options or something that happens outside of the state
11 or different financing mechanisms or whatever. I think
12 that if we look at it from the standpoint of these classes
13 of -- as we have in the past started to peel away the
14 layers of some of these classes of drugs, classes of
15 therapies, what it means to the beneficiary, what costs it
16 imposes on the system, et cetera, then that might help us
17 understand some of those different approaches that could be
18 used.
19 COMMISSIONER WEIL: I just have to say I would
20 not agree that the rebate system works effective for the
21 vast majority of drugs. Just put that on the record.
22 CHAIR THOMPSON: Well, say more about that, Alan,

1 meaning the --

2 COMMISSIONER WEIL: Oh, I don't know where to

3 start. I mean, I would almost want to turn around the

4 question and say, "How does it work well?" I mean, it

5 generates -- it certainly gives Medicaid a better price

6 than a lot of other payers, and that's a good thing.

7 Whether it's the right amount, I don't know. We've heard

8 presentations about the variable ability of states to

9 generate -- what's the word? Not supplemental -- yeah,

10 supplemental rebates based on criteria that I frankly don't

11 think relate to value or anything like that. And it's all

12 based off of prices that are completely -- in large

13 respect, completely arbitrary.

14 So to say that it creates a dollar flow and gives

15 states a better deal than other payers based on something

16 that makes no sense, I agree, blowing it up isn't good

17 because you don't want to ship all that money back. Look,

18 I don't want to dominate the discussion here. I think we

19 learned -- I feel that I -- this is not an area that I felt

20 to be expert in. I feel that I learned, and read our

21 report, it's long, good and long. You know, the ecosystem

22 of pricing is not value -- is not related to value. That

1 is -- and so a rebate structure off of something that has
2 no relationship to -- little relationship to value doesn't
3 to me solve the problem.
4 CHAIR THOMPSON: Thanks for that.
5 I have Fred and then Darin.
6 COMMISSIONER CERISE: Well, gee whiz. Just to
7 follow a little bit on that, it is -- and, again, I was in
8 the camp of I realize we don't want to blow up the rebate
9 program and start that over. But, you know, the system
10 that it's based on, you know, these different piecemeal
11 approaches, we're going to give rebates, we're going to
12 have patient assistance programs, we have just these
13 different approaches that you really are trying to solve a
14 public health issue, is not -- is not the way you would
15 design it from scratch, let's say. And so if there is a
16 way to push more transparency, you know, the fact that
17 you've got these negotiated deals and the Secretary can't
18 even see the dollars, you just see a dollar sign or three
19 dollar signs, because you're going through some other
20 entity, it's just absurd.
21 And so, again, I'm not saying it shouldn't be our
22 agenda to take on rebates, but I agree with Alan. I

1 wouldn't shy away from that discussion because it's just
2 not a -- it's a complicated system for a reason, you know,
3 because people are making money off of a complicated
4 system, and there's a lot to be made here.
5 Just a couple of specific comments. I do agree
6 that perhaps a way we could make a statement is to create
7 some room for this to look at these a little bit
8 differently. For instance, as I'm thinking about Rebekah's
9 business -- if that's successful, you're going to have one
10 vendor, right? I mean, you're going to have one drug
11 because I don't know how you would do a subscription
12 service that didn't say, okay, we're going to pick you and
13 just you to do the whole population. So, you know, you're
14 going to have to have some flexibility to work through
15 these things that we don't have today. And then if that's
16 successful, there really are national implications that go
17 well beyond Louisiana. So just some thoughts around that.
18 On the specific, I thought Paul's points on the
19 accelerated approval process were important points, things
20 like, you know, the ability for states to look at that and
21 say, you know, we're going to limit to label or we're going
22 to limit to what the clinical trial actually says it was

1 effective to do is important, and I wouldn't pass on that,
2 either.
3 COMMISSIONER GORDON: So I agree with Fred, your
4 comments there. Also, to echo Alan's comment, the drug
5 rebate system is a tool, albeit an imperfect tool. And so
6 it could be improved upon. So I don't think we completely
7 blow it up, but I do think we do have a conversation, are
8 there things that could be done to improve it or to come up
9 with a different model that, to Alan's point, drives more
10 toward value, being based on value as opposed to a formula
11 that can in essence be backed into in the rate development
12 process?
13 Medicaid best price keeps coming up, and I do
14 think we should consider recommending, whether it's
15 statutory or whether it's through some other means,
16 somewhat of a safe harbor for exceptions to Medicaid best
17 price when it is a situation that is, you know, a value-
18 based purchasing arrangement that is being negotiated
19 between the state and that particular manufacturer or, you
20 know, you can get an advanced value-based purchasing, not
21 that it's superficial but something of substance, because
22 whether it's a real hurdle or not, practically speaking it

1 is limiting some of the development of some more creative
2 arrangements between states and manufacturers around some
3 value-based purchasing models, and I think a narrow safe
4 harbor or exception around that might be worth considering.
5 MR. PARK: Can I just make one clarification on
6 Medicaid best price? So if the state enters into a value-
7 based arrangement with a manufacturer and it is considered
8 a state supplemental rebate, that is not --
9 COMMISSIONER GORDON: That is not --
10 MR. PARK: That is not considered best price, and
11 that would --
12 COMMISSIONER GORDON: Correct, exactly. But my
13 point being it's in that narrow realm of if it's involving
14 supplemental rebates, and I think that creativity can go
15 well beyond that, so I think -- I mean, thank you for
16 clarifying. There is that -- and Dr. Gee even pointed to
17 it. There's some work-arounds to Medicaid best price,
18 supplemental rebates being one of those, but I think
19 there's probably more potential out there beyond that if
20 given the room to do so.
21 CHAIR THOMPSON: Okay. What I want to try to do
22 is, you know, I think we have -- we owe the staff some

1 guidance on exactly what we want them to focus on and some
2 of the things that we think are most apt to produce insight
3 and recommendations that we can act on. And I think, Alan,
4 your point that there might be some room to interject
5 ourselves and some discussions is absolutely right, but
6 that also puts some pressure on us around making some
7 choices and setting some priorities and making sure that
8 what we have to offer, you know, has the appropriate
9 evidence and database to be compelling and useful to that
10 conversation.
11 So, Chris, having heard some of what we've said,
12 I know we were talking a little bit at the break about
13 whether this lens of looking at certain classes and types
14 of drugs and how well or not well the rebate program kind
15 of serves or doesn't serve, in addition to kind of keeping
16 some of these other mid-tier or lower-tier looks at tweaks
17 and modifications and improvements on the rebate program
18 going. Does that seem like something that you think
19 provides a framework that we can use for discussion? And I
20 think bringing in the National Academy recommendations and
21 conversations as part of that as well, is that enough
22 guidance for you to be able to think about some potential

1 ways in which you can come back with some data and
2 suggestions for us?
3 MR. PARK: We can, I can think about it. I
4 think, you know, Dr. Gee made the analogy to the Vaccines
5 for Children Program.
6 CHAIR THOMPSON: Right, exactly.
7 MR. PARK: So there may be some cases where
8 there's a strong public health interest where maybe you
9 take that class of drugs, like the hepatitis C curative
10 treatments, and move that outside of the rebate program.
11 CHAIR THOMPSON: Right.
12 MR. PARK: You know, Dr. Jeffrey had mentioned
13 some of the cell and gene therapies, so that might be
14 another place where --
15 CHAIR THOMPSON: Where you're in an amortization
16 kind of model --
17 MR. PARK: Yeah, or even, you know, like a narrow
18 kind of definition of what is -- like maybe certain things,
19 because particularly with how these are being paid for in
20 the inpatient setting, you know, should these be kind of
21 considered outside of the outpatient drug program. So I
22 think we can certainly think about that. I think the

1 challenge will be kind of like if you really want to be
2 specific in trying like how to identify, you know, does
3 this therapy deserve special consideration or not, I think
4 that's where we would have the challenge of trying to come
5 up with that level of detail. But if you wanted to make
6 more of a broad statement of here are the types of things
7 that maybe CMS should consider and have authority to carve
8 out of the drug rebate program, that might be where the
9 Commission could come up with at least some kind of
10 recommendation language that, you know, kind of doesn't put
11 the onus on the Commission to say Classes A, B, and C
12 should be carved out, but, you know, would give CMS or
13 another entity the authority to kind of make that decision.
14 CHAIR THOMPSON: Okay. I just want to make sure
15 that, when we go about this, we don't single-thread this
16 onto -- it gets back to this point that we need some
17 different levels of creativity being exercised here. And
18 so, you know, the administration came forward with an idea
19 about, you know, here's -- let's allow five states to go
20 in. That was why I was asking Dr. Jeffrey about like,
21 well, okay, is the problem there it's an all-or-nothing
22 proposition and so you can't totally walk away from the

1 rebate program. And so is there some different kind of an
2 approach where there's an ability to segment that risk in a
3 different way to present some flexibility, again, with the
4 idea of delivering needed therapies to beneficiaries, but
5 produces a different relationship or a different way of
6 purchasing or a different cost profile to the state. So I
7 want to think about that, too, so that it isn't just, you
8 know, the federal government -- suggesting that the federal
9 government preplan out all of the places where there might
10 be a different exercise of state authority or a different
11 economic model that could be used. So just think about
12 that, too.
13 MR. PARK: Sure.
14 CHAIR THOMPSON: Whether there's something more
15 structural about how states decide to be a part of the
16 rebate program or not and give some kind of middle ground
17 so that it's not an all-or-nothing proposition.
18 Fred, do you want to jump in?
19 COMMISSIONER CERISE: Yeah, I thought Paul, some
20 of his points, it's out there. You know, like the state's
21 going to determine what the price -- what's a fair price.
22 Essentially what you're doing is you've got this huge

1 population you say you must cover, you must buy the drug
2 for, and you must pay what is being determined is -- so I
3 think, you know, the thought along what Paul was
4 describing, how do you get to something that's fair, and I
5 realize that's controversial, but it's also controversial
6 that we've got tens of thousands, hundreds of thousands of
7 people with hep C that just aren't getting the drug at all.
8 And so it's a sticky thing, but, you know, I think the
9 economic model and how do you work on behalf of the
10 Medicaid program to buttress the negotiation on that side.
11 CHAIR THOMPSON: Martha.
12 COMMISSIONER CARTER: I'm a little hesitant to
13 weigh in because drug pricing is not my area of expertise.
14 But I was particularly intrigued with Dr. Gee's
15 description, and perhaps it would be helpful for us to
16 frame a conversation around drugs that are potentially
17 curable - are curative. So, you know, infectious diseases
18 like hep C or some of the gene therapy, because there's a
19 different business proposition for pharmaceutical companies
20 when they're developing those drugs. And so there should
21 be -- it makes sense that there might be a different
22 pricing model, and maybe even a rebate model -- I just

1 can't go there -- for those drugs, because they're not like
2 a drug that's going to be -- that a person is going to take
3 for a long time.
4 And so that might be just a class -- it's messy,
5 but it's a class of drugs that are projected to be fairly
6 immediately curative, which means they have a shorter
7 business life, if you will. I don't know the correct
8 terminology. Because I think that would be an area to
9 innovative in and to think about pricing differently.
10 CHAIR THOMPSON: Okay. Great. Good
11 conversation. Chris, as usual, we look to you to come back
12 with some maybe additional structure, based on this
13 conversation, and some ideas about some modeling or
14 analytic approaches that could be useful to help us
15 continue these conversations. So much appreciated.
16 CHAIR THOMPSON: Okay. Our next session is going
17 to be on network adequacy in managed care.
18 **### NETWORK ADEQUACY IN MANAGED CARE**
19 * MS. FORBES: All right. So the plan for this
20 session, I'll recap why this is on the agenda again; remind
21 you of the federal standards for network oversight in
22 Medicaid managed care since we last discussed this in

1 September; explain the work that staff did to look into
2 this area; and go over our initial findings.
3 During your discussion at the September meeting
4 about Medicaid managed care oversight, you raised questions
5 about the adequacy of oversight and about meaningful
6 oversight, how the requirements and processes translate
7 into accountability.
8 CMS is considering two regulatory actions that
9 could affect managed care access oversight. The equal
10 access rule would exempt states from fee-for-service access
11 monitoring if they have more than 85 percent of enrollees
12 in managed care. As you may remember, the Commission sent
13 comments in last May. CMS is still working through its
14 process on that rule.
15 The managed care notice of proposed rulemaking
16 came out on November 14. We will talk about that later
17 this afternoon. It also includes some proposed changes to
18 network oversight, so this session today is timely.
19 Several oversight provisions of the current rules
20 went into effect in 2018, just this last July. This
21 includes rules requiring all states to follow the same
22 standards and to have network standards in their quality

1 strategies. So this year is really our first chance to
2 look at states and find out what they are doing.
3 There are federal rules which have evolved over
4 time for how states and MCOs must ensure that people who
5 are enrolled in Medicaid managed care have timely access to
6 services. There are several things that states must do:
7 develop network adequacy standards and access requirements
8 for a range of provider types; include a contract provision
9 requiring MCOs to document their compliance; list the
10 network adequacy standards and access requirements in a
11 state formal quality strategy, and make those publicly
12 available on a state website; monitor the availability and
13 accessibility of services, including network adequacy
14 standards; and impose sanctions if necessary.
15 CMS has also provided some regulatory guidance to
16 assist states in implementing these rules. In April 2017,
17 CMS published a toolkit that included a framework for
18 developing network adequacy and access standards and
19 suggested metrics for monitoring provider network adequacy
20 and service availability to assist states in developing
21 these quality strategies and update their network standards
22 in time for these 2018 rules to go into effect.

1 We wanted to see how states put all the pieces on
2 the previous slide together – standards, monitoring, and
3 enforcement -- to implement meaningful oversight. There
4 are 42 states with comprehensive managed care programs. We
5 wanted to collect the most current publicly available
6 contracts, network adequacy standards, and quality
7 strategies from as many states as we could. We ended up
8 attempting searches for 20 randomly chosen states and we
9 were able to find documents from 14 of them. It would have
10 been more but the rule came out in the middle of our work,
11 so we ended up getting about a third.
12 We reviewed the documents to identify the degree
13 to which they comply with the requirements of the current
14 rule and implement the suggestions in the CMS toolkit. We
15 were hoping to inform the policy questions raised in the
16 earlier Commission discussions regarding meaningful federal
17 and state oversight, so I'll walk through our findings in
18 the various areas now.
19 The rules promote transparency by requiring
20 states to put certain information on the state website,
21 including the network standards, the state quality
22 strategy, and the base or model contract with the MCOs.

1 The contracts were supposed to be online as of July 1,
2 2017, and the quality strategy and the network standards as
3 of July 1, 2018. Most states that we looked at -- again,
4 we found information for 14 -- have a draft or final
5 quality strategy available online. Some states hadn't
6 updated the online version for several years so we weren't
7 always sure if we were looking at the most recent version.
8 We went with what we could find online.

9 A lot of states incorporate the network standards
10 into other documents that are available online, such as the
11 quality standards or the MCO contract, so they were
12 available. They just weren't always a standalone document.
13 Some states provide a model contract online and some states
14 provide copies of the actual contracts with their MCOs,
15 which, for transparency purposes, you know, either will do.
16 And some states include things like network standards or
17 required reports, access monitoring procedures, and other
18 documents like operations manuals or contractor's scope of
19 work that they reference. They incorporate, by reference,
20 into the documents that we are looking at. So if we looked
21 at a contract and the contract said "we're incorporating
22 this by reference" and they had a link, then we would look

1 at that document as well.

2 We looked to see, first, how states defined
3 network adequacy and access and the metrics they used to
4 measure and monitor provider networks. The requirements
5 can include things like time and distance standards,
6 standards related to timely access, such as appointment
7 wait times, things like provider-to-enrollee ratios. We
8 also looked for standards relevant to specific populations,
9 things like pediatrics or obstetrics, and for comparison
10 benchmarks from fee-for-service or commercial insurance,
11 some of those measures of realized access.

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

20 Very few states described metrics that could be
21 used to measure realized access or network adequacy beyond
22 time and distance. You know, all of the states said you

1 have to maintain a network of providers to meet geographic
2 access standards, but we only found a few that had a metric
3 beyond that, to see what beyond that would be considered
4 acceptable. Florida requires, for example, that a specific
5 percentage of PCPs accept new Medicaid enrollees.
6 Many states described access goals and access
7 monitoring in their quality strategies, but the goals were
8 described in terms of visits or clinical outcomes, not
9 network access measures. For example, Delaware -- this is
10 just an example -- has a statewide goal to improve timely
11 access to appropriate care in services for adults and
12 children, but the measures are HEDIS measures for adult
13 access to primary and preventive care services. They said
14 they look at quality of care and complaint data. They
15 would look at critical incident reports to monitor
16 progress. They didn't really talk about network access and
17 adequacy. They talked about more outcomes measures in
18 terms of how they would look at that.
19 We also looked to see how individual states
20 specified the network adequacy standards and reporting
21 requirements in the actual contracts. States have a lot of
22 flexibility in determining the format and timing of the

1 network documentation that they require. The only federal
2 requirement is that it has to be at least annual or
3 whenever there is a significant change.
4 Most of the contracts we looked at had a number
5 of provider and access-related reports that MCOs had to
6 submit, in addition to that detailed provider file. For
7 example, Arizona requires MCOs to report unexpected changes
8 in provider networks. Georgia requires reports indicating
9 the percentage of members without access to a provider
10 within the time-and-distance standards. Kansas requires
11 MCOs to report on visits to non-participating providers.
12 We saw a lot of different examples.
13 Many contracts we reviewed also require other
14 information that could be used for access and network
15 adequacy monitoring, such as member grievances, provider
16 grievances, surveys, encounter data. Also, many states now
17 require MCOs to develop something like a comprehensive
18 network development plan, which is similar to a
19 comprehensive quality improvement plan. That's an option.
20 It's not a federal requirement but many states are now
21 requiring sort of a comprehensive approach to how a plan is
22 thinking about network access and adequacy.

1 We looked at the documents to try and determine
2 how states are monitoring network access and the managed
3 care program as a whole. States can use a variety of
4 mechanisms to monitor networks and overall program access.
5 They can look at the reports and analyses that the MCOs are
6 doing, or they can develop their own analyses using program
7 data. They can contract with their external quality review
8 organizations to conduct analyses on their behalf. All of
9 the states are getting, obviously, their periodic MCO
10 provider network files and the reports from the MCOs.
11 Most states appear to be using multiple methods
12 to monitor access, including compliance with the time-and-
13 distance standards as well as other measures of access and
14 availability. All 14 states we reviewed either required
15 the MCOs to conduct a member survey or the state to conduct
16 a member survey, or both. Half the states also conduct or
17 require their MCOs to conduct a provider survey. Nine of
18 the states explicitly said that they were using the
19 provider file or they were requiring the MCOs to do
20 geomapping analysis, to demonstrate compliance with the
21 time and distance. Again, that was the ones where they
22 said that they were doing that. There may be more that are

1 doing that as well.

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

11 And finally, we reviewed MCO contracts to
12 determine whether there were penalties associated with
13 network and access deficiencies or network and access
14 specific reporting failures. States are allowed to impose
15 financial and non-financial penalties on MCOs for failure
16 to comply with any provision in federal statute or
17 regulation. Most of the contracts we reviewed listed only
18 the sanctions that are explicitly listed in the federal
19 rule. While this rule allows states to impose sanctions if
20 an MCO misrepresents or falsifies information, which would
21 include network information, we didn't count this. It's
22 not sort of explicitly a network adequacy enforcement

1 mechanism.

2 About one-third of the contracts we reviewed
3 included financial penalties specific to network access
4 deficiencies or network reporting failures. For example,
5 Florida's contract allows it to penalize MCOs $5,000 for
6 failure to report significant number of changes in a timely
7 way, and $500 per day for failure to provide services
8 within the geographic standards. And we were able to find
9 reports from Florida that they are actually routinely
10 collecting fines from MCOs. Georgia, similar to Florida,
11 has different penalties for access violations and for
12 reporting violations. Georgia's contract allows it to
13 penalize MCOs $100,000 per violation for failure to provide
14 an adequate network to provide sufficient access by
15 provider type, and $5,000 per day for failure to submit
16 attestations or reports.

17 So our goal was to provide you with more
18 information on how states conduct meaningful oversight of
19 network adequacy and access, and to try and do that by
20 reviewing the publicly available information from state
21 Medicaid managed care programs in order to bring this back
22 to you this fall. We reviewed state documents to learn how

1 they're implementing federal requirements to ensure that
2 enrollees in Medicaid managed care have timely access to
3 services, and we hope to inform some of the policy
4 questions that have been raised in earlier Commission
5 discussions regarding meaningful oversight.
6 We learned that despite federal rules requiring
7 states to make certain information available online, it
8 would be difficult for a member of the public, including
9 managed care enrollees and providers, to locate a lot of
10 these documents. All of the documents we reviewed yielded
11 information on what is monitored. We weren't able to learn
12 a lot from just looking at them, just from the document
13 review, about how states use the information they collect
14 to identify potential problems. In particular, the lack of
15 performance metrics makes it difficult to understand what
16 level of deficiency triggers corrective action or contract
17 sanctions. Of course, again, it was reviewed -- our review
18 was limited to publicly available documents and we could
19 learn more about meaningful oversight if there is further
20 work you would like us to do.
21 So with that I am happy to answer any more
22 questions about our findings or our approach, or if there

1 are additional things you'd like us to follow up on we're
2 happy to do that.
3 VICE CHAIR LAMPKIN: Thanks, Moira. That's
4 really helpful baseline information.
5 I have a couple of questions and maybe some
6 things I'd like to see a little bit more. But the
7 questions, where you able to determine -- and I understand
8 it was a limited review of publicly available information -
9 - were you able to determine, from what you looked at, able
10 to provide any insights as to how the states are thinking
11 about a couple of things in the context of network
12 adequacy. One is essential providers and safety net
13 providers. Are they being factored into network adequacy
14 requirements, and if so, how? And the second,
15 telemedicine.
16 MS. FORBES: So we didn't -- so our approach was
17 we looked at the guidance that CMS put out and sort of the
18 high-level indicators in different categories of access
19 that it had noted, and looked for those in the various
20 documents. And essential providers and safety net
21 providers and telemedicine were not high enough level
22 things for us to have specifically sort of checked those

1 off as we went through the documents. I did see that many
2 states, you know, had either listed those as things that
3 they collected information on, had provider standards for,
4 or had an exception policy for, but I didn't sort of
5 systematically collect that information as I went through
6 them. So I can say that states are doing that but I cannot
7 quantify that for you.

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

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

16 The other thing -- I don't know that we've talked
17 about it much in the Commission, but related -- another
18 thing that happened in the 2016 managed care regulation is
19 that CMS now requires actuaries in the context of rate
20 setting to consider network adequacy challenges and gaps as
21 they think about capitation rate development. And so that
22 has, as you can imagine, a lot of us really trying to think

1 about, well how do you do that and what does that mean,
2 because there are all kinds of reasons things that could
3 cause gaps in network adequacy that don't translate into a
4 capitation rate adjustment, for example.
5 And so one of the things that I'm curious about,
6 coming out of that train of thinking and conversation
7 that's happening within my profession, is what are states
8 finding in terms of where there are gaps in the standards,
9 how are states managing that? So this comprehensive
10 network development plan that the MCOs have to provide in
11 the states that have that, does that address how you
12 resolve gaps, and what kinds of gaps are responsibilities
13 for MCOs to resolve, and do they have the tools to resolve
14 versus the state versus the market? You know, how are
15 states wrestling with that question of how to resolve the
16 gaps and whose responsibility it is?
17 MS. FORBES: So that's a good question. So what
18 is required in a network development plan would be
19 outlined, generally, in an RFP, which is not a document
20 that we looked at. I have helped MCOs respond to RFPs and
21 I have written these documents. And so the kinds of things
22 you're talking about could be addressed in a network

1 oversight plan, and we could go find -- I know some of the
2 states that require those, and so that's something that we
3 could pull some information on. And that is exactly the
4 sort of thing that an MCO would be, you know, how are they
5 -- where they're identifying gaps. Are they looking at
6 alternative payment strategies? Are they looking at
7 workforce development? Are they looking at providing staff
8 extenders through MCO staff? What are the different
9 mechanisms that they're using to help, you know, support
10 access? So those are the kinds of things that the MCO
11 might do. So we could certainly collect more information
12 on that.
13 In terms of the linkage to the cap rate guidance,
14 we didn't look at that. We didn't see a lot of information
15 on how there's a connection between what is being required
16 on the network side and what is required on the payment
17 side. We didn't see, I think, anything on the federal cap
18 rate review side about how that piece is being enforced.
19 VICE CHAIR LAMPKIN: Right, and that actually
20 wasn't part of my question. That was just the lead-in to
21 why I've been having a lot of conversation about network
22 adequacy gaps, you know, among my colleagues and clients,

1 and what does that mean. And so I think that that is a
2 useful -- not just because of the actuarial challenge, but
3 to me it seems like a useful avenue to pursue that's really
4 outcome oriented and meaningful, is how are states and MCOs
5 approaching different network adequacy gaps that are caused
6 by different kinds of challenges. Are the states just
7 going, "Oh, you're right? There is no pediatric
8 cardiology" -- I don't know, a great specialty -- "in that
9 particular part of the state. I'll give you a waiver of
10 your network's adequacy requirement because there aren't
11 any," or how are they approaching these kinds of issues?
12 It's just, I think, an area that would be fruitful for us
13 to look at further.
14 Darin?
15 COMMISSIONER GORDON: Yeah. I think what's hard
16 is, getting to your question, it's not laid out in the
17 contract. It's more or less the process of the state
18 administrator. So in our case, you know, there would be a
19 request for a corrective action. The corrective action
20 plan is does it seem reasonable to solve the problem and
21 then follow up, did they actually implement it, and
22 validate that it's working. And you don't have that in a

1 contract. It's more of an administrative process, which is
2 hard for you all to get at without a more extensive review.
3 I think the other component of that -- and this
4 is something I saw over 20-some-odd years, where we didn't
5 get some things right -- we had, in our contracts, in some
6 cases, network standards that were arbitrary and
7 capricious. We just made them up, apparently, because, you
8 know, the expectation, in some cases, was that the health
9 plans would build a hospital where a hospital didn't exist.
10 And for many years, in the early part of the program, those
11 plans were assessed damages for not having a hospital in
12 those communities. And again, we had to re-evaluate.
13 So one of the things that, when we looked at that
14 and said, that's setting people up to fail, we ended up
15 including language in our contracts around community
16 standard, to recognize, in some cases, that in those
17 communities that provider is just not available, and the
18 demographics couldn't support it, but what's your plan,
19 still, to how you get folks access to those services. So
20 that's where it gets complicated, because particularly in -
21 - I mean, every state's got its own unique geography, and
22 where the providers are and how things shift, and how you

1 account for that. In our case, what we had done is we had
2 just developed some stuff not knowing, and it stayed there
3 forever until we re-looked at it and tried to make sure it
4 made sense with what the market looked like today.
5 VICE CHAIR LAMPKIN: And I definitely didn't
6 expect that the review that has already been conducted
7 would be turning up stuff like that, but as we just think
8 about what further avenues do we think are fruitful for us
9 to explore, understanding how states know, is this a
10 reimbursement issue, or is it something else? And does it
11 tie back to do we want to think about graduate medical
12 education and the way we structured that program in the
13 state related to this or not? Those kinds of things would
14 be interesting but probably case study or limited state
15 investigation-type studies.
16 Brian and then Sheldon.
17 COMMISSIONER BURWELL: I think we are going to
18 build on the same theme of how states use network adequacy
19 standards to provide access to services that are currently
20 not as available to Medicaid members as we would like them
21 to be. So I'm interested in a more dynamic approach about
22 how this policy tool is used by states to increase access

1 to certain services.

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

14 VICE CHAIR LAMPKIN: Okay. Sheldon.

15 COMMISSIONER RETCHIN: First, I really appreciate
16 the effort. I really enjoyed reading your findings, Moira.

17 I always like it when we pick up the phone and
18 call the states and figure out what's going on at ground
19 zero.

20 I always have a problem, however, with the time
21 and distance standards as really the indication for network
22 adequacy, and maybe it's just me.

1 I live 12 minutes from Ohio Stadium. I'm a
2 faculty member at Ohio State, but I can't get a ticket for
3 the Michigan game. I might be in the network, but I don't
4 really get access to the goods.
5 And I was really interested, Moira, when you
6 looked at the sample of states that you called. Maybe you
7 already mentioned this and I was out of the room, but did
8 you see any difference in the ability of states that have
9 expanded Medicaid? Maybe this is a territory I am not
10 supposed to go into, but I will, anyway.
11 In particular, the certain specialties that may
12 be relatively rare, I would have thought would have
13 difficulty in assembling a network like oncology. That
14 they would have a difficult time. Did you hear that?
15 Because it's a different population.
16 MS. FORBES: We looked at what they're requiring,
17 not so much what they're achieving.
18 COMMISSIONER RETCHIN: Oh, okay.
19 I do think that coming back to this and looking
20 at the ability for monitoring and evaluation of being able
21 to roll out these networks is really important.
22 VICE CHAIR LAMPKIN: Darin.

1 COMMISSIONER GORDON: And just, Sheldon, to your
2 point that you just brought up -- and I think you touched
3 on it a little bit about what others -- what states are
4 doing like through their EQROs to do some additional
5 validation, that while folks are meeting those standards --
6 because I think the standards in and of themselves, like
7 you said, are insufficient. There's all these additional
8 things that have to be done, and I think you identified
9 some of the things that states are doing in that regard.
10 The area -- and this is what I've always thought
11 because time and distance is one thing. Validating really
12 what's going on at those practices is another. Monitoring
13 your call lines, even, to identify, while it may look like
14 there's a dot on the map, if there's some access issues
15 that are occurring, what you're doing with that
16 information.
17 But, also, this is why it's such a complicated
18 factor, so I applaud you for all what you were able to get
19 online because some of this stuff just doesn't come to the
20 level of them posting it online, but even looking at the
21 fact that you have some providers getting to your specialty
22 and subspecialty situations, some markets where there's a

1 single provider and not just on Medicaid -- you see it on
2 the commercial side as well -- that won't go in network but
3 will see your members and validating that that in fact is
4 happening through claims data, because they want to control
5 their panel size and the distribution amongst the different
6 payers, so it gets really complicated really quick.
7 So I think those time and distance standards is a
8 base-level test, and then there's all these other things
9 that you described and even more that need to be done to
10 have a more accurate picture of really what's happening.
11 VICE CHAIR LAMPKIN: Kathy and then Bill.
12 COMMISSIONER WENO: Yeah. Just to follow up on a
13 lot of what we're talking about, dental networks are a big
14 problem, and when I worked in Kansas, in the western two-
15 thirds of Kansas, there was only one pediatric dentist.
16 You're talking about at least over 2- to 300 miles, even to
17 find someone that would qualify for that. So, although
18 time and distance standards are important, in some cases
19 they're relatively meaningless.
20 Then the other thing among dental that was
21 particularly challenging is accountability. Most MCOs
22 would use a dental administrator to do their networks and

1 create another level of accountability and difficulty in
2 trying to pin an MCO to a network standard, who was
3 collecting that data and who would you call. You could
4 really get quite the runaround, so it was an interesting
5 place to work.
6 COMMISSIONER SCANLON: I know in other contexts
7 that the receipt of a service is considered a process
8 measure and not an outcome measure, but I think here,
9 receipt of the service is really an important outcome.
10 The standards, payment rates, and anything else
11 that plays into that actual access, I think is key.
12 For me, the time and distance in part is part of
13 the message that you cannot be satisfied by too high of a
14 level of examination in terms of geography. If across a
15 broad area, we've got access meets some standard of 70, 80
16 percent, that may not be very reassuring because we may
17 have pocket areas where people are not getting access, and
18 I think that needs to be looked at.
19 It's very analogous to what we were talking about
20 in earlier discussions about oversight with respect to fee-
21 for-service. If only 10 percent of the population is still
22 in fee-for-service, is that reason to not monitor what's

1 happening to them? Because they may be 10 percent of the
2 people for whom access is a critical issue, and I think the
3 same thing needs to apply here. We need to look to an
4 outcome which, in this case, is actual access, and
5 secondly, we need to disaggregate it enough that we can
6 really feel reassured that the access is sufficient for the
7 subpopulations that are involved.
8 VICE CHAIR LAMPKIN: Anybody else?
9 [No response.]
10 VICE CHAIR LAMPKIN: What I think I was hearing
11 going around is some interest in learning more about other
12 metrics, other than time and distance, what states are
13 using them and how they are using them; maybe a little bit
14 more on certain providers and provider types and the
15 structure around that, essential providers. Modalities
16 like telemedicine, I think that would be interesting; then
17 maybe down the road, network adequacy gaps and solutions
18 for them.
19 I think I was the only one really making that.
20 CHAIR THOMPSON: I'll chime in to say I agree
21 with that.
22 COMMISSIONER GORDON: Yeah, I agree too. I'd say

1 it's how states are -- how they react to those gaps.

2 VICE CHAIR LAMPKIN: That's right. Yeah.

3 Martha.

4 COMMISSIONER CARTER: Moira, do any of the states

5 use surveys of their PCPs to analyze their specialty gaps?

6 Have they sent surveys to beneficiaries, which is sort of a

7 proxy for access?

8 I know if I went and talked to our primary care

9 providers, they would be able to tell you in a heartbeat

10 where they can't get their patients in for specialty care.

11 Does anybody do that?

12 MS. FORBES: So this is the limitation is that I

13 know that they do a provider survey.

14 I know in the beneficiary survey, they use CAHPS,

15 and I can look at the CAHPS questions. I don't know what

16 states are using for provider surveys or what questions the

17 MCOs are asking, but that's the sort of thing if there's

18 interest, we could try and get more information on what --

19 COMMISSIONER CARTER: I know I've never seen one,

20 a survey like that.

21 MS. FORBES: Yeah.

22 COMMISSIONER CARTER: It would be really

1 interesting.

2 MS. FORBES: We could try and find out.

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

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

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

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

1 happening?

2 So I think this question of how do you make use

3 of the human intelligence in the field and the family

4 members, the providers, and others who can provide insight

5 into, in reality, "I cannot get an appointment, and I

6 cannot get care that I need," how does that information

7 structure play into this, I think that's a useful thing to

8 think about.

9 VICE CHAIR LAMPKIN: All right. If that's it on

10 network adequacy, we adjourn for lunch.

11 CHAIR THOMPSON: Okay. We will be back at -- I

12 think the schedule is calling for us to be back at one

13 o'clock. Okay. We will be back at one o'clock. Thanks,

14 everyone.

15 * [Whereupon, at 12:05 p.m., the meeting was

16 recessed, to reconvene at 1:00 p.m. this same day.]

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1 AFTERNOON SESSION

2 [12:59 p.m.]

3 CHAIR THOMPSON: All right. We'll give the one-
4 minute warning, please.

5 [Pause.]

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

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

11 **### DISPROPORTIONATE SHARE HOSPITAL ALLOTMENT**
12 **REDUCTIONS: PROPOSED RECOMMENDATIONS**

13 * MR. NELB: Great. Thanks, Penny.

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

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

22 I'll be looking for your feedback today on the

1 recommendation language itself as well as on the rationale
2 that will accompany the recommendations. As part of that
3 rationale, we're also proposing to include some design
4 considerations for Congress to consider if they did choose
5 to implement the policy, and then we're also required to
6 comment on the expected impact of the proposal on the
7 federal government, states, providers, and enrollees.
8 At our last meeting, you asked for some more
9 information about the state-by-state impact, so I'll be
10 providing some more information about that today,
11 specifically with a focus on the states that are most
12 likely to be affected by the proposed policy.
13 And, finally, I'll wrap up by talking about some
14 other DSH policy options that you might want to consider in
15 the future. These are some ideas that you've raised in
16 previous meetings, but that don't appear to be quite ready
17 for a recommendation at this time. But we can keep an eye
18 on it for the future.
19 So, first, some background. DSH payments, as you
20 know, are limited by federal allotments, and these
21 allotments vary widely by state, based on DSH spending in
22 1992 when the limits were first established.

1 The ACA included reductions to DSH allotments
2 under the assumption that the increased coverage would
3 reduce hospital uncompensated care costs and, thus, lessen
4 the need for DSH payments.
5 These DSH cuts were initially scheduled to take
6 effect in 2014, but they've been delayed several times.
7 Under current law, reductions are scheduled to
8 begin in fiscal year 2020 at a $4 billion cut, and then
9 reductions increase to $8 billion per year in fiscal years
10 2021 through 2025. This is an amount that's a little more
11 than half of states' unreduced allotment amounts.
12 Under current law, there is no reduction
13 scheduled in fiscal year 2026 and subsequent years, and so
14 in those years, the allotments will return to their higher
15 unreduced amounts.
16 The statue currently requires CMS to develop a
17 methodology to distribute reductions based on several
18 factors listed in the statute. Specifically, CMS is
19 required to apply larger reductions to states with low
20 uninsured rates and is also required to apply larger
21 reductions to states that do not target their DSH payments
22 to hospitals with a high volumes of Medicaid patients or

1 high levels of uncompensated care.

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

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

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

16 Based on feedback from our last meeting, we
17 developed a package of three recommendations for you to
18 consider. These include, first, phasing in reductions more
19 gradually over a longer period of time; second, applying
20 reductions to unspent funding first; and third,
21 distributing reductions in a way that gradually improves
22 the relationship between DSH allotments and the number of

1 non-elderly, low-income individuals in a state.

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

5 So let's dive into the specifics. The proposed
6 text of the first recommendation is as follows: "In order
7 to phase in DSH allotment reductions more gradually without
8 increasing federal spending, Congress should revise Section
9 1923 of the Social Security Act to change the schedule of
10 DSH allotment reductions to $2 billion in fiscal year 2020,
11 $4 billion in fiscal year 2021, $6 billion in fiscal year
12 2022, and $8 billion a year in fiscal years 2023 through
13 2029."

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

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

22 However, it's important to note that since we're

1 not proposing specific legislative language, CBO isn't able
2 to give us a specific point estimate for the
3 recommendation, and so at a later time, if Congress does
4 choose to implement this recommendation, it would get the
5 specific costs or savings associated with it and could make
6 other adjustments, as needed, to achieve our goal of
7 minimizing changes in federal spending.
8 The second recommendation reads as follows: "In
9 order to minimize the effects of DSH allotment reductions
10 on hospitals that currently receive DSH payments, Congress
11 should revise Section 1923 of the Social Security Act to
12 require the U.S. Department of Health and Human Services to
13 apply reductions to states with DSH allotments that are
14 projected to be unspent before applying reductions to other
15 states."
16 The intent of applying reductions to unspent
17 funds first is to minimize the amount of reductions on DSH
18 funds that are currently being spent and are currently paid
19 to providers. In fiscal year 2016, about $1.2 billion in
20 federal DSH allotments were unspent, and so this amount
21 could offset most of the amount of reductions in the first
22 year under our current proposal.

1 Moreover, the amount of unspent funds by state
2 has been relatively consistent year to year, and so it's
3 likely that funds that have been unspent in the past will
4 continue to be unspent in the future.
5 The memo that you have describes a number of
6 different, more specific design considerations that
7 Congress may want to consider if it did choose to implement
8 this policy.
9 First, we talk about the method that we used in
10 our analysis to project unspent funding. Specifically, we
11 averaged unspent funds for the past three years in order to
12 help smooth any year-to-year variation.
13 Second, we note that even though in our analysis,
14 we weren't able to take into account funds that may be
15 unspent in the future after reductions take effect, it is
16 plausible that Congress could develop some method where
17 those funds that continue to be unspent are reallocated to
18 other states, similar to the process that's currently used
19 for unspent CHIP allotments.
20 Finally, I just want to point out that we
21 highlighted a small technical change in the statute that
22 could help clarify that reductions to unspent DSH funds

1 don't affect DSH funds that are currently spent on
2 providers.
3 All right. Last but not least is Recommendation
4 3, which focuses really on this new methodology that we're
5 proposing. The language reads as follows: "In order to
6 reduce the wide variation in state DSH allotments based on
7 historic DSH spending, Congress should revise Section 1923
8 of the Social Security Act to require HHS to develop a
9 methodology to distribute reductions in a way that
10 gradually improves the relationship between DSH allotments
11 and the number of non-elderly, low-income individuals in a
12 state, after adjusting for differences in costs in
13 different geographic areas." A bit of a mouthful.
14 So the purpose of this recommendation is really
15 to begin that process of aligning allotments with a more
16 objective measure of need. As you'll recall at our last
17 meeting, we talked about a number of different potential
18 measures that could be used, and at the time, most
19 Commissioners felt that the number of low-income
20 individuals in the state was a good measure because it
21 related to hospital uncompensated care costs and also it
22 was relatively independent of state coverage choices.

1 As you will recall, we did consider basing
2 allotments based on uncompensated care reported on Medicare
3 cost reports or on DSH audits, but there were some concerns
4 about the reliability and completeness of those data. And
5 then we also looked at potentially basing allotments on the
6 number of uninsured individuals or the number of Medicaid
7 enrollees in the state, but we found that those measures
8 were highly affected by state coverage choices.
9 Commissioners also expressed support for making
10 adjustments to account for variations in costs in different
11 geographic areas. In our analyses, we used the Medicare
12 Wage Index to make that adjustment.
13 Finally, I want to point out that we're proposing
14 to phase in changes gradually in order to provide states
15 and hospitals more time to respond before the full amount
16 of reductions takes effect.
17 So our recommendation doesn't propose a specific
18 methodology that CMS should apply, but as part of the
19 design considerations that we're putting forth, we kind of
20 walk through some of the assumptions that we made when
21 we're trying to estimate how this proposal may work in
22 practice.

1 So your memo goes into the full set of
2 assumptions that we made, but I just want to highlight two
3 here. First, because we're trying to implement the
4 rebasing along with allotment reductions, we assume that
5 the reductions to states with very large allotments would
6 be larger than any increases to states with allotments that
7 are below the rebased amount, so in order to achieve that
8 full amount of cuts in those first four years.
9 Second, to deal with some of these outlier cases
10 where the state's DSH allotment is so much larger than the
11 national average, we assumed that there would be a maximum
12 reduction amount, and for our purposes, we assumed 30
13 percent a year.
14 These are just assumptions, however, and I think
15 we anticipate that Congress would direct CMS to define many
16 of the specific details of the methodology, similar to what
17 it does under current law, and this would likely happen
18 through the rulemaking process, which would provide
19 opportunities for stakeholders to comment and for CMS to
20 respond to those comments.
21 However, it's important to note that the timing
22 for rulemaking is quite short, since under current law,

1 reductions begin in fiscal year 2020, which actually begins
2 in October of next year.
3 So looking at the expected impact of all of our
4 recommendations together, CBO estimates that the proposal
5 will result in some modest federal budget savings over the
6 2019-through-2029 budget period. CBO is not able to
7 estimate the effects of each component of the
8 recommendation separately.
9 The effects on states will vary, and I'll get to
10 that in just a bit. But, in general, compared to current
11 law, this proposal would result in larger reductions for
12 states' unspent DSH funds, and it would also result in
13 larger reductions for states that have particularly high
14 DSH allotments per low-income individual.
15 The effects on providers and enrollees will also
16 vary by state, and it will also depend on how states
17 respond to reductions. As I'll discuss, it is possible
18 that some states may attempt to offset the effects of
19 reductions by increasing other types of Medicaid payments
20 to providers, but it's hard to predict exactly how that
21 will work.
22 So now let's take a closer look at some --

1 EXECUTIVE DIRECTOR SCHWARTZ: Rob?

2 MR. NELB: Oh.

3 EXECUTIVE DIRECTOR SCHWARTZ: Can I just

4 interrupt here?

5 MR. NELB: Yeah.

6 EXECUTIVE DIRECTOR SCHWARTZ: I want to just

7 clarify. CBO did say that it had a modest budget saving.

8 Our goal going in was to have it be budget neutral, but it

9 was hard to configure it to be exactly neutral. And in any

10 case, those parameters would change so much in legislative

11 language. So I just want to clarify that it's not intended

12 to take more savings out, and that is something that we

13 could also comment on in the writing of the chapter and in

14 the rationale for the recommendations to clarify that our

15 intent was to just deal with the amount of savings that had

16 been currently projected.

17 Then Congress could figure out, for example if it

18 was a little bit of a saver, what they wanted to do with

19 that, if they want to put it back into this or if they

20 wanted to adjust some parameter.

21 CHAIR THOMPSON: Thank you. That's an important

22 clarification.

1 MR. NELB: Yeah, definitely. Great.

2 Okay. So now let's take a closer look at the
3 state-by-state effects. So this figure shows the projected
4 reduction in state DSH spending as a share of total
5 Medicaid hospital spending by state under the proposed
6 policy, when the full amount of reductions takes effect in
7 2023.

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

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

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

21 So now this slide focuses on the seven states
22 that are projected to have DSH payment reductions that are

1 greater than or equal to 10 percent of their Medicaid
2 hospital spending in 2023.
3 As you can see, this list includes a mix of
4 expansion and non-expansion states that have a variety of
5 different characteristics. However, the common theme for
6 all of them is that they currently have very large DSH
7 allotments per low-income individual, and so under this
8 rebasing policy, they are expected to receive large
9 reductions. In fact, all of these states receive
10 reductions up to that maximum that we assumed in our
11 policy, the 30 percent a year.
12 So the first two columns here compare reductions
13 under current law to the proposed policy, and I just wanted
14 to highlight the example of Alabama where the reductions
15 under the proposed policy are actually less than under
16 current law. This sort of comes back to the fact that
17 under either scenario, we are still dealing with the same
18 amount of cuts, the $8 billion amount, and as we think
19 about this methodology, it's important to remember that any
20 policy that reduces cuts for some states will result in
21 larger cuts for other states, and so there's a tradeoff
22 there.

1 The third column has information about Medicaid
2 shortfall reported on DSH audits in 2014. In some ways,
3 this represents the amount that states could potentially
4 offset by increasing other types of Medicaid payments to
5 hospitals.
6 So here, I highlight the example of New York,
7 which is projected to receive a pretty large cut, $3
8 billion in state and federal funds; however, New York
9 reported more than $4 billion in Medicaid shortfall for DSH
10 hospitals in 2014.
11 And the final column includes information about
12 the share of DSH payments to deemed DSH hospitals in 2014.
13 As you will recall, deemed DSH hospitals are statutorily
14 required to receive DSH payments because they serve a high
15 share of Medicaid and low-income patients, and in our prior
16 analyses, we found that these hospitals tend to have higher
17 levels of uncompensated care and more financial challenges
18 compared to other hospitals.
19 So another way that states may respond to cuts,
20 especially in the case of Missouri where they don't have
21 any Medicaid shortfall that they reported, another way to
22 potentially respond is to better target the remaining funds

1 to hospitals that need it most. So Missouri is a case
2 where they distribute their DSH funds pretty broadly, and
3 if they choose in the future could potentially target a
4 larger share of those payments to deemed DSH hospitals or
5 whatever subset of hospitals they think are most in need.
6 So this slide further explores some of the
7 different non-DSH payment methods that states may be able
8 to use to offset the effects of DSH reductions, if they
9 choose.
10 First, in both fee-for-service and managed care,
11 states could increase base payment rates to providers,
12 which are tied to Medicaid utilization.
13 Second, in fee-for-service, states can make upper
14 payment limit supplemental payments, known as UPL payments.
15 These are lump-sum payments, and states have pretty broad
16 flexibility about how they target them.
17 And then, third, in managed care, states can now
18 make directed payments to providers, which operate pretty
19 similar to UPL payments in terms of being an extra payment
20 that goes to providers, but there are a couple more
21 parameters around how those funds are distributed.
22 As you recall, last summer we spoke with

1 Louisiana as part of our hospital payment interview
2 project, and we learned more about their plans to shift
3 about $379 million in DSH payments to base rate increases
4 to providers. The state was doing this not only to get
5 ready for DSH allotment reductions but also as part of
6 their larger policy goal of reducing reliance on
7 supplemental payments. And, you know, as part of this
8 change, the state isn't adding any more state general funds
9 but it's just shifting the funds that were currently
10 available from one payment method to another.
11 We spoke to Louisiana and they mentioned that it
12 took them about three years to implement this policy
13 change, which included time, not only for all the system
14 upgrades and sort of developing the new method, but also a
15 lot of consultation with stakeholders. Even though the
16 total amount of funds under the new policy were the same as
17 before, some hospitals that we spoke with were, you know,
18 concerned that the distribution of payments may shift under
19 the new methodology and they wanted to be prepared for
20 that.
21 The last point I want to make about other non-DSH
22 payment methods is that although states have a number of

1 ways that they can pay for Medicaid shortfall, it's more
2 difficult for states to replace DSH payments that are
3 paying for care for the uninsured. In addition, it's also
4 harder for states to replace DSH payments that are going to
5 institutions for mental diseases, or IMDs, since IMDs are
6 not otherwise eligible for Medicaid payments for services
7 provided to enrollees between age 21 and 64. There are
8 some new waiver opportunities now but that general payment
9 limitation still exists. And it's important to note that
10 in 2014, about 14 percent of DSH payments were made to
11 IMDs.

12 All right. Last but not least, I just want to
13 walk through two other DSH policy options for future
14 consideration. First, recall that at the September meeting
15 we talked about a recent court ruling that changed the DSH
16 definition of Medicaid shortfall, saying that payments from
17 third-party payers, such as Medicare or commercial
18 insurance, can no longer be counted. And as a result of
19 this, we expect that Medicaid shortfall reported on future
20 DSH audits will more than double in the aggregate. So, for
21 example, with dual eligibles, Medicare paid about $25
22 billion for those hospital services provided by duals.

1 Under the new policy those payments no longer count but the
2 costs of care for those patients is still counted as
3 Medicaid shortfall, and so it sort of distorts the amount
4 of Medicaid shortfall reported.
5 The result is that it will end up increasing the
6 amount of DSH payments that an individual hospital is
7 eligible to receive, but also, in some states it could
8 result in a redistribution of funding, particularly in
9 states that distribute DSH funds based on the amount of
10 uncompensated care reported on DSH audits. So one
11 possibility is that it would result in fewer funds for
12 hospitals that serve a high share of uninsured patients and
13 more funds for hospitals that serve more patients with
14 third-party coverage, such as children's hospitals.
15 So, let's see. Although states are now making
16 DSH payments under the new policy, it's a bit difficult for
17 the Commission to make a recommendation on this topic at
18 this time because the litigation surrounding this issue is
19 still ongoing. Specifically, the outcome of the litigation
20 will determine whether or not MACPAC would need to make a
21 recommendation to Congress or a recommendation to CMS in
22 order to change this policy.

1 I also want to point out that there are some
2 other pending lawsuits related to this issue, specifically
3 about when the timing of this change should take effect,
4 which just sort of further complicates our ability to weigh
5 in on this issue at this time.
6 Nevertheless, even though we're not making a
7 recommendation on this issue, we could still highlight it
8 and comment about it in our report.
9 All right. Another policy that Commissioners
10 have discussed a lot is the idea of using DSH funding to
11 help support delivery system transformation. Specifically,
12 we've been monitoring California's global payment program,
13 which is a Section 1115 waiver that's testing the policy of
14 distributing DSH funds as a global payment, tied to quality
15 goals. The interim evaluation results of this demo came
16 out earlier this year and they showed some promising signs
17 of expanded access to care and better financial stability
18 for the hospitals that were participating. The final
19 evaluation results are expected next summer and that will
20 give us some more information about how utilization has
21 changed under the policy.
22 To help other states adopt similar models, CMS

1 could provide enhanced technical assistance to states to do
2 a similar demo, similar to what they've been doing for
3 other types of demos. However, at the September public
4 meeting some Commissioners were a bit skeptical about
5 whether other states would be interested in pursuing this
6 path, especially at this time when DSH funding is being
7 cut.
8 So that concludes my presentation for today. I
9 look forward to your feedback on the proposed
10 recommendations so that we can prepare them for a vote at
11 the January meeting. The recommendations will be
12 accompanied by a draft chapter that further walks through
13 the Commission's analyses and alternatives considered, and
14 I plan to have a draft of that chapter for you in January
15 as well.
16 Thanks, and I look forward to your feedback.
17 CHAIR THOMPSON: Thank you, Rob. First of all,
18 great job, as always, in capturing some of the direction
19 from our prior conversations. And I think this lays out
20 very clearly and very well a lot of the things that we've
21 been discussing, in terms of both the recommendations and
22 the impacts on how that plays out for different states and,

1 potentially, hospitals.

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

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

16 There is a separate case which is about, again,
17 the timing. And so CMS first applied this policy through
18 an FAQ and then they subsequently issued rulemaking. And
19 so there are questions about if it's ruled that you should
20 count these third-party payments whether CMS can enforce
21 that policy sort of retrospectively, or whether it's just
22 something on an ongoing basis.

1 But at least the subject of the court rulings are
2 more around the legal authority. I think you'll talk to
3 different stakeholders and will have different views on
4 whether, you know, this policy makes sense or not. I mean,
5 some of the children's hospitals are particularly concerned
6 about the inclusion of the commercial payer payments, which
7 end up -- if those commercial payments are above costs,
8 what it ends up doing is reducing the amount of payments
9 that those hospitals can receive for the true Medicaid
10 shortfall that they are having for Medicaid-only
11 recipients.
12 CHAIR THOMPSON: So they see it as a cost
13 shifting issue.
14 MR. NELB: Yes. Yeah. So there are definitely
15 hospitals that are concerned about this issue, but the
16 merits of it, the legal case, are focused on sort of who --
17 whether CMS or states that can --
18 CHAIR THOMPSON: Okay. Thank you for that
19 clarification.
20 All right. So we're going to have a little bit
21 of a Commissioner conversation. We'll have public comment,
22 and then we'll come back to the Commissioner conversation.

1 As Rob mentioned, we are set up to take a vote in January.
2 If the Commissioners are ready to take votes now we can go
3 ahead and move on to that. We'll see how the conversation
4 progresses.
5 So I saw Melanie and then I saw Bill, and then I
6 see Darin.
7 COMMISSIONER BELLA: Thanks, Rob. The
8 recommendations make a lot of sense. My comment is not on
9 the recommendation. It's actually, can we go to Slide 17?
10 I just want to clarify one thing. It's the slide that has
11 -- oh, sorry, 20. I got my numbers wrong. The circles.
12 The New York circle.
13 So I just want to -- move back to the circles.
14 Sorry. I just want to make sure I'm understanding. So
15 we're basically saying one of the options for the states is
16 to just redirect what currently is in DSH payment to a base
17 payment and then buy down, in this case, some of the
18 shortfalls. Is that what we're saying that the states
19 could do?
20 MR. NELB: Yeah. Either a base payment or a non-
21 DSH supplemental payment they could make as well.
22 COMMISSIONER BELLA: Have we gotten any feedback

1 from states on thinking about that?
2 MR. NELB: I think the experience we had in
3 Louisiana is sort of the best example that we had, in that
4 it's like theoretically possible and some are considering
5 doing it. It's hard to do, and especially in cases where
6 those payments are financed by providers, shifting around
7 the distribution of the payments may affect the ability of
8 the states to get the same level of IGTs, or the
9 willingness of the providers to pay.
10 COMMISSIONER BELLA: Yeah, that's where my head
11 was going, just in that case, the ability of the state to
12 really be able to do that with state funds.
13 CHAIR THOMPSON: So your point is not to
14 overstate, oh well, they could just flip it over here --
15 COMMISSIONER BELLA: Right.
16 CHAIR THOMPSON: -- and do this.
17 COMMISSIONER BELLA: Right.
18 CHAIR THOMPSON: Right. Uh-huh.
19 COMMISSIONER BELLA: Maybe some could easier than
20 others.
21 And then on the third-party payment thing, I just
22 wanted to go on record to say it seems absurd, particularly

1 in the case of duals. Now what you just said, about the
2 children's hospitals and commercial is a different angle,
3 so maybe we think about parsing it differently. But in the
4 case where it's the Medicaid-Medicare overlap, like it just
5 doesn't make any sense. And so I would encourage that we
6 would include it in the chapter, and then when there is a
7 ruling, hopefully we would make a statement.
8 CHAIR THOMPSON: Well, that's where I was going,
9 Melanie. I'm sort of like, even though it's a point of
10 litigation, if the issue is some drafting language it
11 doesn't seem to me that that should necessarily preclude
12 us. So I think maybe there is a judgment to be made about
13 how far we want to go with respect to statements about
14 that, because I think there was a reaction of all of the
15 Commissioners to that conversation last time, as well.
16 Okay. Bill.
17 COMMISSIONER SCANLON: Yeah, I'm going to start -
18 - I was going to do a comment and a question -- I'm going
19 to start with the question because it's about this third-
20 party payment. I'm confused as to whether it's being
21 applied in the aggregate or on an individual basis.
22 Because when you cite children's hospital, I think if

1 someone comes in with private insurance are they also going
2 to be paid by Medicaid and identified as a Medicaid person?
3 That happens? Okay.

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

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

22 My comment was about, I think I wanted to say

1 thank you for including the cost adjustment in this
2 recommendation, because I feel like it's an incredibly
3 important precedent. We have historically ignored the fact
4 that there are these very significant cost variations
5 across states, and so therefore you get a federal dollar.
6 What is buys in different states is very, very different.
7 It also goes to the whole question of eligibility, and when
8 we have standards like 100 percent of FPL. It means a very
9 different thing to be living at the poverty level in an
10 expensive state versus sort of a lower-cost state. And so
11 I think this, again, is a very important thing for us to be
12 doing in this process.
13 CHAIR THOMPSON: Darin and then Alan.
14 COMMISSIONER GORDON: So, one, to take on with
15 Mellie's comment, when she talked about the ease of raising
16 base rates, obviously there are some complicating factors.
17 Or I should back up -- thank you for all the work you've
18 done on this. I'm very grateful. On that comment that she
19 made about it can be more complicated that they have that
20 as an avenue to raise the base rates, I think that's
21 absolutely valid. But at the same time I also think their
22 ability to transition those to supplemental payments, as

1 the view on supplemental payments has changed from
2 administration to administration, for the 20-some-odd years
3 I've been involved in Medicaid, so that's not always a
4 given either, what that would look like.
5 But your point in either, actually, I guess, in
6 the base rate situation is a good one, and everyone needs
7 to recognize it's a complicating factor, that it helps
8 address some of the challenge and loss but there's not a
9 perfect formula to adjust base rates to hold people
10 harmless for the adjustment, so to speak. On the
11 supplemental payment side that could be different,
12 depending on how that's structured. So that was one
13 comment.
14 I feel comfortable with a lot of your
15 recommendations. One I still struggle with, and I'm not
16 comfortable with, is where we're getting to the point where
17 coverage is not a factor. Just looking historically at
18 disproportionate share hospital payments and it being for
19 uncompensated care, a big factor of uncompensated care is
20 because someone does not have coverage. And the fact that
21 we're not considering that seems -- and I remember the
22 discussions, our discussions, but just from a personal

1 perspective I have a hard time supporting that, given the
2 history of why disproportionate share hospital payments
3 came into being.
4 CHAIR THOMPSON: Alan.
5 COMMISSIONER BELLA: I'm sorry. Can I just ask
6 one quick question?
7 CHAIR THOMPSON: Yeah.
8 COMMISSIONER BELLA: This is on, would it be
9 interesting then for us to look at all states in that last
10 column to see how many of their DSH payments are actually
11 going -- I mean, where they're going? Would that be
12 something that -- I guess, Darin, what I'm trying to figure
13 out is have we gotten so far away from intents?
14 COMMISSIONER GORDON: You're saying try to see
15 how much of it is going for uncompensated care versus --
16 COMMISSIONER BELLA: Well, the share of payments
17 going to -- well, I'm just trying to figure out, it seems
18 like we've gotten pretty far away from intent, the way some
19 of the payment -- where the payments are going --
20 COMMISSIONER GORDON: Some of the formulas.
21 COMMISSIONER BELLA: -- and I was just curious if
22 that's worth looking at.

1 COMMISSIONER GORDON: Yeah, it's definitely worth
2 looking at. It would be helpful. It's just something --
3 again, it's a component that, on its face, that I struggle
4 with, and it's one that I have a hard time supporting.
5 But, yeah, additional data may make that more clear to me
6 why that wouldn't be such a big change.
7 CHAIR THOMPSON: Stacey, you wanted to jump in?
8 VICE CHAIR LAMPKIN: So I was one of the folks at
9 the last meeting who also preferred the count of uninsured,
10 for some of the reasons that you just said. But going back
11 to original intent was disproportionate share of both
12 uninsured and Medicaid recipients. So, I mean, I got the
13 point about the low-income individuals kind of going back
14 to original intent from that content. Are you --
15 COMMISSIONER GORDON: I'm saying excluding the
16 one doesn't feel right, the uninsured component, and that's
17 what I took the third recommendation as that coverage is
18 not a factor any longer, in the recommendation, and
19 uninsured, I think, should be a factor, continue to be a
20 factor.
21 CHAIR THOMPSON: Yeah. I mean, the discussion
22 that we had last time, which I thought was interesting too,

1 was a little bit about this issue of there's a lot of
2 different reactions and choices that states can be making,
3 taking into account what they're getting in terms of DSH
4 funding. So we talked a little bit about you can get money
5 to hospitals through different avenues. You can also
6 reduce some of the need by coverage choices, of varying
7 kinds, that states have made over the years and continue to
8 have in front of them. And I think part of the issue was
9 to try to avoid disincentivizing or incentivizing any one
10 of those particular policy levers or recognition that all
11 of those become available to states to make some of the
12 decisions, and that the low-income population, which has a
13 higher proportion of Medicaid coverage, has a higher
14 proportion of uninsured rates, was kind of a neutral
15 element of population attributes that could be used to make
16 some of these decisions. So that still may not be
17 compelling to you, Darin, but that was --
18 COMMISSIONER GORDON: No. I mean, all valid
19 points. So when we did TennCare back in the day we got rid
20 of our DSH, and the intent behind getting rid of our DSH
21 wasn't because, you know, it wasn't that your Medicaid loss
22 goes down. In fact, we're going to cover more people on

1 Medicaid. It was a reduction in the uninsured population.
2 Now, granted, it was not a wise decision back then to
3 completely get rid of your entire DSH, as others, the ACA,
4 got it that, you know, just because you have 100 percent
5 coverage, even in a place where you would have 100 percent
6 coverage, you're still going to have some uncompensated
7 care at facilities, and Massachusetts saw the same thing.
8 I hear you. My point being, though, is the
9 uninsured is a big factor in what those hospitals are doing
10 with uncompensated, and regardless of what we do, I am
11 convinced every policy I've ever made creates incentives
12 and disincentives. Not doing it creates incentives and
13 disincentives as well.
14 CHAIR THOMPSON: Anne is looking to jump in.
15 EXECUTIVE DIRECTOR SCHWARTZ: Yeah. I just want
16 to jump in to remind you that at this level we're talking
17 about distributing a pot of money across states, so it's
18 about where states sit relative to each other. And it's
19 also, when you will recall the last meeting, Rob had these
20 three different measures and their correlation with
21 uncompensated care costs, and none of them were head and
22 shoulders above the rest.

1 So I think that's worth thinking about. When you
2 do it based on the uninsured, it's not like it takes you
3 much, much closer to some nirvana of deciding who needs it
4 most. But keeping in mind both of those things, the
5 distribution and the fact that none of these measures were
6 incredibly highly correlated or preferable to each other
7 from that perspective.
8 CHAIR THOMPSON: And this one was actually the
9 one in the middle, in terms of level of correlation.
10 COMMISSIONER GORTON: And let me just ask, Anne,
11 would you then contemplate, in the rationale that went with
12 the recommendation, to say precisely that, and essentially
13 give the pros and cons?
14 EXECUTIVE DIRECTOR SCHWARTZ: Absolutely.
15 Absolutely.
16 COMMISSIONER GORTON: So that we would say you
17 could, in some ways, the uninsured population felt, to many
18 Commissioners, as being closer to the original intent, but
19 it wasn't a better measure and it's subject to coverage
20 decisions by individual states. And so, in the end, we
21 gravitated towards the low-income number, but arguments can
22 be made. I mean, do we have to be that specific about this

1 indicator in this recommendation, or can we say, look,
2 there are no perfect choices. There aren't even any really
3 good choices. But, you know, we think the least bad of the
4 choices is this one.
5 EXECUTIVE DIRECTOR SCHWARTZ: I will answer that
6 in two parts. One is we absolutely can and should in any
7 rationale describe the Commission's decision-making
8 process. My caution would be in not recommending something
9 is that if you want Congress to do something that you think
10 is better, then I think if you can come to a decision that
11 would be based on data, that would be our value add here as
12 opposed to what we might imagine Members of Congress
13 gravitating to.
14 CHAIR THOMPSON: Yeah.
15 EXECUTIVE DIRECTOR SCHWARTZ: So that's a two-
16 part answer.
17 CHAIR THOMPSON: I'll just reinforce that idea.
18 I think as much as possible our contribution is to have the
19 Commissioners weigh in on what seems on the basis of the
20 evidence better or not as good. If we're saying, well, you
21 know, just in general it should be -- you should think
22 about something or in general it could be different, I

1 think that's understanding that people already have.

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

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

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

20 I am a little worried about where this
21 conversation is going, talking about perfect or
22 imperfection or alignment. This is a value choice about

1 whether allocation should be based on need as defined by
2 uncompensated care. Then there's a question of is it --
3 how perfectly can we measure uncompensated care? Or should
4 it be based on need as defined by the inherent demographics
5 of a state?

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

17 I'm going to toss out, just to be annoying -- I
18 have to say, Bill, your comment made me realize there's
19 some real complexity in the phrase "after adjusting for
20 differences in cost" that I don't actually think we've
21 grappled with because the way you said it, there are
22 actually a lot of different ways of thinking about what

1 that means. One is to say the DSH allocation should be
2 adjusted by the input factors. But we know that
3 eligibility -- well, we know that larger -- lower-income
4 states have higher rates of Medicaid coverage because of
5 standardized eligibility. We also know that DSH is
6 matched, and the matching formula takes into account state
7 income characteristics.
8 We are not writing statute here, and all we're
9 saying is that Congress should tell HHS to do it. But I
10 actually think the phrase "after adjusting for differences"
11 is really ambiguous, and I'm not sure how quickly we can
12 figure out what we mean by it, but I actually don't -- I'm
13 in favor of it, but I'm not sure at this point I even quite
14 know what we mean by it.
15 CHAIR THOMPSON: Bill, do you want to jump in?
16 COMMISSIONER SCANLON: I think we definitely have
17 to explain exactly what we're doing, but some of these
18 other factors that you talked about are already being
19 incorporated, and this is one that has been left out
20 historically all the time. We do not recognize that there
21 are differences in input costs that are going to -- that
22 are significant and are going to affect the volume of

1 services that are financed out of a given set of dollars.

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

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

22 CHAIR THOMPSON: Fred.

1 COMMISSIONER CERISE: Thanks. So, first, I'll
2 comment without trying to prolong the discussion of the
3 uninsured too much longer. I do think some comment about
4 that -- and I think Rob did a good job. I'm reading what
5 you had on page 7 of the report that you acknowledge that
6 that is an issue, because I don't think there's uniform
7 agreement on that point, which you're not going to get, and
8 I recognize that. I think it's much better than status
9 quo, but the truth is the uninsured is a huge issue there
10 with uncompensated care costs that the hospitals feel, and
11 so to at least acknowledge that and say states have the
12 ability to affect this. States can make a decision and can
13 impact that. But I do think some reference or discussion
14 of that would be helpful.
15 A couple of other things. I think you guys have
16 said a lot about the Medicaid loss, the shortfall, and I
17 agree with that.
18 Rob, in your text you talked about some other --
19 it sounded like more minor things, but things that may, as
20 you maybe tweak the leftover funds or something, the
21 hospitals -- the states that target more towards deemed
22 hospitals may be a factor there, sort of more of a minor

1 factor. I don't exactly remember how you included that,
2 but it was raised as a question of, you know, do you want
3 to comment on that? And I don't know if you can do this.
4 When you look at the targeting of deemed hospitals, it
5 doesn't really reflect reality in a lot of situations
6 because of the way states use IGT. And so you will see
7 this targeting where it's not really targeting. And so I
8 don't know if it's possible to tease that out and to show
9 targeting after you've teased out the IGT to see, you know,
10 if states really are targeting or spreading, because I
11 think some of those states that look like they're targeting
12 are really spreading more than it appears.
13 And then, finally, the California global payment
14 thing, I think particularly since states may have a little
15 more flexibility to address the Medicaid shortfall with
16 rates and things like that, and less so the uninsured,
17 although you've got the ability to do both, I wouldn't
18 necessarily throw that out as something not to consider or
19 to comment on just because, you know, I'm interested to see
20 how that plays out and if it is an option to replace some
21 of these things in a coordinated system of care, I think it
22 would be worth commenting on.

1 CHAIR THOMPSON: Okay. Why don't we go to the
2 public and see if there's any commentary?
3 ### PUBLIC COMMENT
4 * MS. GONTSCHAROW: Hi. Good afternoon. My name
5 is Zina Gontscharow with America's Essential Hospitals, and
6 we really appreciate the Commission and staff's hard work
7 around DSH payments and the thoughtful consideration of
8 ways to soften the blow of the impeding DSH reductions on
9 states and hospitals. However, we really encourage the
10 Commission to include in its recommendations to clearly
11 state how devastating that these cuts would be and the
12 magnitude of these cuts would really have a great impact on
13 hospitals, especially essential hospitals across the
14 country.
15 In addition, we appreciate the conversation and
16 recognition that it is a little difficult for states to
17 just quickly turn around and use another funding stream to
18 support these hospitals, and we encourage the Commission to
19 make that really clear in its recommendations.
20 Thank you very much. We appreciate the
21 opportunity to comment.
22 CHAIR THOMPSON: Good. Thank you.

1 Any other comments?

2 [No response.]

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

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

13 CHAIR THOMPSON: Brian, are you jumping in?

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

22 MR. NELB: Sure, so I had to work through the

1 full word problem, but the way our --

2 [Laughter.]

3 MR. NELB: The formula we were thinking of is,

4 you know, there's that $1.2 billion in unspent funds, and

5 basically sort of before we start applying reductions that

6 are based on this rebasing methodology, we cut from that

7 $1.2 billion first. So what it effectively does is it

8 reduces the amount of cuts for other states in that first

9 year.

10 COMMISSIONER BURWELL: But it's applied on a

11 state-by-state basis, these unspent funds have been -- are

12 divided.

13 MR. NELB: So, yeah, for each state we projected

14 the amount of funds that would be unspent in 2020, for

15 example, and then --

16 COMMISSIONER BURWELL: So you have to spend your

17 unspent funds --

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

19 EXECUTIVE DIRECTOR SCHWARTZ: Don't you take them

20 off the top, Rob?

21 MR. NELB: Yeah.

22 EXECUTIVE DIRECTOR SCHWARTZ: Like you're

1 basically adding them all up, you take them off the top
2 first, and then you take the amount that remains and
3 distribute that around to the states. So the pool of cuts
4 is -- the total pool is smaller by that amount.
5 MR. NELB: And the other piece is that --
6 COMMISSIONER BURWELL: Does that change the total
7 amount of reductions over the entire period?
8 MR. NELB: No, so we're still at the $2 billion,
9 $4 billion, $6 billion, and $8 billion.
10 COMMISSIONER BURWELL: So that 1.2 counts towards
11 the $2 billion, basically.
12 MR. NELB: Yes.
13 COMMISSIONER BURWELL: And so the actual amount
14 of reductions, real reductions is less.
15 MR. NELB: The net effect of the reductions is
16 less.
17 COMMISSIONER BURWELL: I got it.
18 CHAIR THOMPSON: Okay. So I think what we have
19 is -- I want to come back to one point. So we've given you
20 some feedback about some of the discussion that we want to
21 have. I think if you can come back with more on third-
22 party payments, people are ready on that subject. And, you

1 know, some of the additional parsing and understanding I
2 think would be helpful to the Commission on that in terms
3 of considering potentially a fourth recommendation. It's
4 also possible that we could just decide that we'll have a
5 longer discussion of it. We may feel like we're not ready
6 to get to a recommendation. We can kind of decide at that
7 point whether it's just a matter of we want to point out a
8 place of concern or attention from the Commission without
9 making a formal recommendation.
10 I do want to consider how we handle -- so we'll
11 give this some thought. I think there is a general view
12 that the recommendations as written are right, but I do
13 recognize that there are places where Commissioners may
14 have some different preferences, and I want to think about
15 how we -- we've talked about voting on this as a package,
16 but I want to be sure that if Commissioners have some
17 things that they want to say, for example, around this
18 issue that we discussed a little bit around, you know, the
19 low-income side versus the uncompensated care, that we
20 appropriately give Commissioners the room to say what they
21 want to say about that. So let's think a little bit about
22 -- you know, it may be a matter of in the voting that we

1 want to be sure that if people want to express that they
2 would have preferred a different way that we want to invite
3 people to say that, and we'll be sure to reflect that as we
4 write up the vote, that there might have been a group of
5 Commissioners who would have preferred a different
6 methodology with respect to Recommendation 3. I just want
7 to allow for that so that the Congress has that information
8 fully reflective.

9 Okay. Any other last points on this topic?

10 [No response.]

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

14 Let's go ahead and move directly into UPL.

15 **### UPPER PAYMENT LIMITS FOR HOSPITALS: PROPOSED**
16 **RECOMMENDATIONS TO IMPROVE COMPLIANCE**

17 * MR. NELB: Great. So I am back for more. So now
18 we're going to look at another set of proposed
19 recommendations related to upper payment limits for
20 hospitals, known as the UPL. I'll begin by providing some
21 background on UPL payments and then review some of the
22 findings that I discussed with you in September related to

1 UPL compliance. And then I'll share a package of two
2 recommendations: first, recommending that CMS develop a
3 process to certify that UPL data are accurate and complete;
4 and, second, recommending that CMS make UPL data publicly
5 available.
6 Just like when we discussed the DSH
7 recommendations, here I'll be looking for your comments on
8 the recommendations themselves as well as the rationale
9 that will accompany the recommendations.
10 And then, finally, we'll conclude by talking
11 about next steps for this chapter and for potential future
12 work on UPL payment policy.
13 So, first on background, as you know, the UPL is
14 an upper limit on aggregate fee-for-service payments for a
15 class of providers, and it's based on a reasonable estimate
16 of what Medicare would have paid for the same service. If
17 Medicaid base payments are below the UPL, then states are
18 allowed to make UPL supplemental payments to help make up
19 that difference.
20 States can make UPL payments to a variety of
21 different provider types, including hospitals, nursing
22 facilities, and physicians, but the vast majority of UPL

1 payments are made to hospitals. So in 2017, for example,
2 $13.1 billion in UPL payments were made to hospitals
3 compared to $4.3 billion in UPL payments to other provider
4 types.
5 In 2013, CMS issued guidance requiring states to
6 demonstrate compliance with the UPL annually. Previously,
7 states would only demonstrate compliance with the UPL when
8 they came in to make changes to their Medicaid state plan.
9 To help states comply with these new
10 requirements, CMS developed templates for states to submit
11 provider-level data in a standard format. These templates
12 have been optional for states since 2014 and are now
13 required for all states.
14 This past summer, we obtained hospital-level UPL
15 data for state fiscal year 2016 for 47 states and the
16 District of Columbia. To better understand these data, we
17 compared them to actual spending reported to CMS, and we
18 also spoke with CMS and several state officials about our
19 findings.
20 While we initially reviewed these data to inform
21 sort of our ongoing work on hospital payment, our analyses
22 identified several sort of more immediate concerns related

1 to just the accuracy and completeness of the data used to
2 monitor compliance with UPL requirements.
3 Specifically, we found some pretty large
4 discrepancies between actual and reported spending, and in
5 some cases these discrepancies were so large that they
6 raised concerns that some states may have made payments in
7 excess of the UPL. Specifically, we found that in 17
8 states the actual amount of UPL payments in state fiscal
9 year 2016 exceeded the UPL limits that were calculated on
10 the UPL demonstrations by $2.2 billion in the aggregate.
11 When we shared these findings with states and CMS
12 officials, they couldn't fully explain the differences that
13 we observed. CMS officials for their part, you know, do
14 expect states to be submitting accurate data on these UPL
15 demos. But the states that we spoke with noted that they
16 were still waiting for feedback from CMS about whether
17 their calculations were correct. And, ultimately, we
18 learned that there's really no process to certify these
19 data after they're submitted to make sure that they're
20 accurate and complete. And the lack of sort of finalizing
21 what the actual UPL limit is limits the ability of states
22 and CMS to actually use these UPL limits when they are

1 reviewing claimed expenditures.

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

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

17 The rationale for this recommendation really
18 begins with the underlying purpose of the UPL, which is to
19 provide an upper limit on Medicaid payments to providers.
20 If UPL limits aren't being enforced when the payments are
21 being made, then they aren't achieving their purpose of
22 having an upper limit.

1 CMS already has existing regulations that require
2 state spending to be below the UPL, and CMS regulations
3 also give it the authority to defer federal funding for
4 spending that exceeds the UPL. However, the gap that we
5 found is that it's challenging for CMS to sort of enforce
6 these requirements because the data that it collects to
7 monitor UPL compliance isn't reliable.
8 As I mentioned, in the years that we looked at,
9 we found examples of billions of dollars of payments that
10 were missing, and we also found large discrepancies in the
11 payment data that were reported.
12 So our thought is that establishing a process to
13 certify that the UPL demonstration data are accurate and
14 complete is an important first step towards making these
15 data more reliable and more usable to enforce the UPL.
16 This recommendation doesn't prescribe a specific
17 process for CMS to follow, and so it's open-ended about
18 whether that certification process could be done by states,
19 by CMS, or by an independent entity.
20 However, in our rationale, we note that we
21 encourage CMS to consider approaches that minimize the risk
22 that UPL payments are recouped retrospectively from

1 providers, since we know that UPL payments are an important
2 source of revenue for many hospitals.
3 Also, regardless of whether states or CMS are the
4 ones that are certifying the UPL data, we recognize that
5 both states and CMS have a joint responsibility to ensure
6 that claimed expenditures are consistent with federal
7 requirements.
8 The ultimate impact of this recommendation
9 depends on whether CMS continues to find evidence of UPL
10 overpayments after reviewing more accurate and complete
11 data. If so, CMS could recoup excess payments to providers
12 using its existing deferral process. However, CBO won't
13 assume any federal budget savings from this proposal since
14 it's really intended to enforce existing law.
15 Depending on how the policy is implemented,
16 states or CMS may have some increases administrative
17 effort. Currently, CMS estimates that the existing
18 inpatient and outpatient UPL templates require about 80
19 hours of state staff time to compete per response.
20 In terms of the effect on providers and
21 enrollees, providers could be affected if it is found that
22 they received payments in excess of the UPL, and then the

1 corresponding effect on enrollees will, of course,
2 depending on how provider respond, if there are cuts in UPL
3 payments.
4 All right. The next recommendation that we're
5 proposing has to deal with transparency. Specifically, the
6 recommendation reads: "To help inform the development of
7 payment methods that promote efficiency and economy, the
8 Secretary of HHS should make hospital UPL demonstration
9 data and methods publicly available in a standard format
10 that enables analysis."
11 Since UPL payments are such a large part of
12 Medicaid payments to hospitals, it is important to
13 understand where this money is going. In 2017, UPL
14 payments were actually larger than DSH payments to
15 hospitals, but unlike DSH payments where they're audited
16 annually and we have that publicly available data,
17 unfortunately we don't have any public data on how UPL
18 payments are spent.
19 This recommendation builds on MACPAC's prior
20 recommendations for more transparency in Medicaid payments
21 to hospitals. While we would ultimately like complete data
22 about all types of Medicaid payments, we recognize that the

1 UPL demonstrations are an existing data source that can
2 fill an important gap without creating a new reporting
3 system for states and CMS.
4 MACPAC's interest in these data is not just only
5 for transparency but also to help inform the development of
6 payment policies that promote the statutory goals of
7 economy and efficiency. For example, more complete data
8 about UPL payments that states make can help inform
9 analyses about whether these payments are well targeted and
10 can help inform our understanding of how they relate to
11 other types of payments to hospitals.
12 The effects of the second recommendation are
13 relatively limited, since states are already providing this
14 information to CMS; however, there may be some increased
15 administrative effort required for CMS to post reports
16 publicly. But this change isn't expected to change federal
17 spending.
18 So that concludes my presentation for today.
19 Similar to the DSH recommendations, our initial plan is to
20 vote on these at the January meeting and to accompany the
21 recommendations with a report chapter that describes the
22 Commission's analyses and findings.

1 You have a draft of this chapter in your
2 materials today, and so I also welcome any feedback you
3 have about the tone, messages, or major conclusions of that
4 chapter.
5 In that report chapter, I just wanted to
6 highlight that we provided a little more background
7 information about the methods that states use to calculate
8 the UPL. At the September meeting, some Commissioners
9 flagged this might be an area for future work, and so I
10 welcome any thoughts you have about more that we can do in
11 that area.
12 Thanks.
13 CHAIR THOMPSON: Great. Okay. I'll jump in
14 first. Then I've got Kit and Darin.
15 I'm having trouble with the first recommendation
16 talking about certification because what certification is
17 somebody saying I attest this is full and complete and
18 accurate, and it's only the state that can do that because
19 that's the state's submission to CMS.
20 I think our issue is that -- and I'm not even
21 sure if it's a matter of are we concerned about
22 certification, per se. It seems like what we're concerned

1 about is that the states submit the information and that
2 they get feedback from CMS and that they finalize the
3 information, and then that CMS use that information. And
4 I'm not sure that that's what reflected in the use of the
5 term "certification."
6 I'll see if other Commissioners have comments on
7 that, but it seems to me that what we want is we want
8 states to submit the UPL demonstration to get feedback from
9 CMS to finalize it, and in so finalizing, they may certify,
10 as they do sign statements on a variety of different things
11 that they send to the federal government about like this is
12 true and accurate to the best of my belief and knowledge.
13 Then we want to be sure that part of that is also
14 that CMS actually consult those data when they are
15 approving state claims for financial match. So it seems
16 like that's what we want to have happen, and I'm not sure
17 the way that we've written it is exactly conveying that.
18 EXECUTIVE DIRECTOR SCHWARTZ: Can I just ask a
19 quick question?
20 CHAIR THOMPSON: Yes.
21 EXECUTIVE DIRECTOR SCHWARTZ: Which is for the
22 purposes of this recommendation, I think what you're

1 talking about is exactly what the staff was trying to
2 achieve. If we just subbed out the word "ensure" and "for
3 certify," if "certify" is like too specific a word with too
4 specific a connotation, and then what's described in the
5 paper gets --
6 CHAIR THOMPSON: Yeah, that might do it. That
7 might do it, yeah.
8 I do think that the word "certify" does have,
9 especially in the financial world --
10 EXECUTIVE DIRECTOR SCHWARTZ: That's fine. I
11 just was trying to figure out --
12 CHAIR THOMPSON: -- a very specific connotation.
13 EXECUTIVE DIRECTOR SCHWARTZ: -- if there was an
14 easy fix.
15 CHAIR THOMPSON: Yeah.
16 Okay. Kit, Darin.
17 COMMISSIONER GORTON: So my reaction to the
18 chapter was that you wrote a pretty compelling argument for
19 why things should change in a fairly major way because
20 potentially billions of dollars of federal money are being
21 misspent.
22 My reaction to the recommendations are that they

1 don't rise to the level of response that I think we should
2 be recommending for what could be a fairly substantial
3 problem.
4 And you've outlined beautifully in your
5 presentation and in the chapter, problem number one is we
6 have no idea how big the problem is because the states
7 don't calculate the limits correctly, and CMS doesn't
8 enforce the limits that they approve, and money just goes.
9 And you are a very gifted and talented analyst, but there's
10 only one of you. And it only took you a few months to
11 figure out that we might have billions of dollars of
12 overspent federal funds.
13 I'm willing to bet that if we gave you and a
14 small army of people a little more time, you would find out
15 in addition that there's huge variation state by state, and
16 that some of the states are being choir girls and boy
17 scouts, and they're doing it. And they're probably under-
18 clubbing it, and so they're getting less than they might
19 get otherwise. And other states are just being very, very
20 creative and assertive in their methodologies, and they're
21 using this frankly as an unmetered piggybank.
22 And given the size of this spent and the lack of

1 accountability, where I came from at the end of reading the
2 chapter was we should be recommending some pretty heady
3 stuff.
4 And I don't know about the technicalities about
5 certify. Should CMS have a process? Yes. They put out
6 templates. That's good. Should they make sure the states
7 fill out the templates right? Yes. Should we make sure
8 that the states get to the right number? Yes. Should we
9 then say that UPL, the "L" stands for "limit." And we
10 wouldn't have to worry about provider recoupments if the
11 states weren't overspending the limit in the first place,
12 right? So there ought to be some process controls in place
13 that keep states within their budgets, like the rest of us
14 have to do, right? If we go bouncing checks all over the
15 place, you don't get to go back to the electric company and
16 say, "Oh, I need that money back because I didn't have it
17 to give to you."
18 The providers shouldn't take it on the chin here;
19 it's the states need to administer the program correctly.
20 And so it seems to me I won't quibble about these, except
21 to say that it really seems to me to be just much too
22 limited response to what seems to be a potential big

1 problem.

2 I know we can't characterize this as a saver from
3 the perspective of the budget, but I think we could
4 probably save a fair amount of money for the taxpayers if
5 it weren't being spent in this way.

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

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

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

22 And then the other place that I would like to

1 potentially see a recommendation is to Congress to exercise
2 its oversight or at least -- and in doing that, yes, the
3 Secretary should do these things and should report to
4 Congress what the findings are, have we sorted this all
5 out. Congress needs to hold the Secretary accountable that
6 he has done -- or whoever it is has done what they need to
7 do in terms of overseeing what you have described as being
8 over 50 percent of the Medicaid hospitals.

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

11 COMMISSIONER GORTON: I do try to be
12 entertaining.

13 [Laughter.]

14 CHAIR THOMPSON: As somebody whose hair went on
15 fire the first time Rob brought this forward. But what I
16 would say, Kit, though, is my perspective is, in a lot of
17 instances, issues that reflect financial vulnerabilities
18 have their answers in very boring, pedestrian management
19 controls and processes, and so there are a variety of
20 requirements on states that don't require them to
21 necessarily disclose and report every aspect or detail of
22 how they do something to the federal government.

1 The only reason that there was even this
2 requirement for annual reporting of UPL was because there
3 had been some problems in the past with states who had had
4 UPLs that kind of reset over time on an automatic basis,
5 and that was not something that ever was subject to federal
6 scrutiny because it was automatic. And those kinds of
7 payments never came up in the context of other state plan
8 amendments and waivers.
9 And so the idea of submitting something on an
10 annual basis was something that was in response to an
11 identified vulnerability, right? That we aren't looking at
12 these things more frequently, and it's one of the things,
13 because it is such a central control, that we ought to be
14 looking at more frequently.
15 I think that there is a process here whereby
16 submitting these data, making sure that they are complete,
17 making sure that they're finalized, making sure that
18 they're then applied to scrutiny over the financial
19 expenditures themselves that will in fact solve the
20 problem. And I think we thought we had kind of maybe
21 solved the problem before, and now we find that, well, we
22 didn't quite clean it up in all the ways that we thought we

1 were going to clean it up, and we didn't quite dot the i's
2 and cross the t's.
3 My view would be also to try to get this settled
4 into a routine and an operational approach that ensures
5 that, you know, the importance of the information is
6 appreciated, the importance of using the information is
7 appreciated, and I think in the end, that will accomplish
8 many of the things that you're talking about trying to
9 accomplish.
10 So I think even though the recommendations come
11 off, perhaps, as kind of like, "Well, yeah, this is what
12 you should do," I actually think they will accomplish what
13 it is that we hope that they will.
14 COMMISSIONER GORTON: I think they may to some
15 extent, and obviously a well-operated process of controls
16 would -- and it's not rocket science that we're talking
17 about.
18 Rob has pulled the curtain back, and what we've
19 seen is that what was built was not enough for a variety of
20 reasons. The states can't price it -- if states can't
21 price it right, then they can't do the calculations right,
22 and if they don't have to live within the calculations --

1 so I do think that what we need is a bunch --

2 CHAIR THOMPSON: Well, we don't know the reality.

3 I mean, that's the thing because we're missing -- what we

4 have is the absence of the management control, which gives

5 us the confidence, not -- but we don't know, in absence of

6 that management control, it may be some things are fine.

7 It's just that we don't have the information and the

8 assurances that we ought to and that we've already

9 demonstrated to be necessary.

10 COMMISSIONER GORTON: Yes. But it's because I

11 think we're missing controls.

12 CHAIR THOMPSON: Yeah.

13 COMMISSIONER GORTON: And I think we're missing

14 several layers of control, and I would just like us to have

15 the Secretary beef up his controls. I would like to have

16 the states -- I mean, certify is good. It does make people

17 pause when they have to sign something and say, "I know

18 this is right." But I think there are controls -- there

19 are detail controls that can be put in place that sort of

20 force the states -- and the templates probably help -- that

21 force the states to go through the exercise and do it

22 properly. There are process controls. Can they price the

1 claims? Do they have access to the Medicare pricing so
2 that they can actually price the claims, which it sounds
3 like some of them are not pricing them?
4 CHAIR THOMPSON: Yeah. That's --
5 COMMISSIONER GORTON: So just let me finish my
6 thought, and I'll shut up. Sorry.
7 But as well, then CMS needs to make sure they did
8 it right. States will struggle. They don't have resource.
9 They need to make sure they did it right, and then they
10 need to hold them accountable to that. And then Congress
11 needs to hold CMS accountable for the whole mess, and so I
12 think there are those three levels of accountability. I
13 don't think there are enough management controls in any of
14 those levels, and I would like to see us go fairly far in
15 saying this is what you need to do. I'm not talking about
16 anything more than that.
17 CHAIR THOMPSON: I want to get the other
18 Commissioners in here.
19 I do think in terms of the question of how do you
20 calculate the UPL, I think it's important we put down the
21 marker that we want to do more work on the how.
22 So some of the things that are about what data

1 are you using, is it really the right data, does that sort
2 of -- we talked before about some broad assumptions that
3 are being made perhaps in some of the UPL demonstration.
4 Maybe we should pay attention to that and take a look at
5 it.
6 I do want to acknowledge that we have some other
7 things, other than this, which was simply about you have
8 not really closed the loop on something that you initiated
9 as a management control to ensure that you had the
10 information on the UPL and that you were using it.
11 Darin and then Alan.
12 Anne, you were trying to get in. Was there
13 something you wanted to say about --
14 EXECUTIVE DIRECTOR SCHWARTZ: No. I was just
15 going to say to Kit that I think all that was what the
16 intent of the chapter was minus the outrage. That one of
17 the press reports recently called MACPAC "cautious and
18 sober," and I think we were trying more on that tone. But
19 the intent --
20 COMMISSIONER GORTON: So this would be outrage.
21 EXECUTIVE DIRECTOR SCHWARTZ: Yeah.
22 CHAIR THOMPSON: Okay. Darin.

1 COMMISSIONER GORDON: So this will be far less
2 colorful.
3 Do we have a sense of what was driving the
4 situations where there were UPLs paid in excess of what the
5 calculations indicated? Was it timing of reports, timing
6 of data? Was it poor processes?
7 A little bit to what Penny is saying, I think
8 there are some questions I have about there's definitely --
9 it sounds like your recommendations are a start in a
10 process, and that's just one of the questions I want to
11 know right -- first off, if you have any sense of that.
12 MR. NELB: Sure. So I think part of the thing is
13 we found there were missing payments and missing hospitals
14 -- missing payments, so, first of all, you know, UPL
15 demonstrations are supposed to calculate that base payments
16 as well as the UPL supplemental payments are below the UPL.
17 But then some states didn't include what their UPL
18 supplemental payments were. And when you put in what their
19 actual UPL payments that they spent were, it was above what
20 they calculated their UPL to be. So first it was just like
21 tracking the actual UPL supplemental payments on these UPL
22 demonstrations as a piece.

1 Another area is we noticed some missing
2 hospitals. There may be some reasons, like for critical
3 access hospitals that are -- other ones that are paid on a
4 cost basis, reasons why they might be excluded. But sort
5 of clearly understanding what's included and not and
6 figuring out a way to track that, and even if those
7 hospitals aren't subject to the UPL, being able to know,
8 you know, what payments are being made to them so you can
9 kind of complete the whole picture and compare it with the
10 state-level data that's on expenditure reports.
11 And then there is a piece -- a lot of these demos
12 are submitted prospectively, and then we were looking at
13 what their actual data was.
14 COMMISSIONER GORDON: Okay, so multiple factors,
15 which I suspect. I like the recommendation. I think
16 that's a good start. I do think it probably won't be where
17 we end because you give more information and figure out how
18 to go deeper than that.
19 I like your transparency one in particular, and
20 one thought, kind of merging your two presentations, you
21 don't have really good data on what they're doing on the
22 UPL side. Then how do you know that it's being backed out

1 in the DSH calculation on the Medicaid shortfall side?

2 MR. NELB: So UPL payments are included in DSH

3 audits, but we only have DSH audits for hospitals that

4 receive DSH payments. So there is another -- you know,

5 only half of hospitals receive DSH payments, and so for

6 that other half, we don't know what they're receiving.

7 The other piece is that on DSH audits it doesn't

8 distinguish between fee-for-service or a managed care base

9 payment, and so the number is sort of -- we can't quite

10 fully match up. But, you know, when we made our previous

11 recommendation around just more transparency in hospital

12 payment in general, I think we had noted that, you know,

13 you could sort of build off what you're already collecting

14 on the DSH audit side, you know, to -- because all those

15 payments are supposed to be captured on the DSH audits, but

16 they're just not presented in a way that we can tease

17 apart, and they're not reported for all hospitals, which is

18 needed to kind of get the full picture of what's happening

19 in a state.

20 COMMISSIONER GORDON: Remind me of the frequency

21 on the DSH audits.

22 MR. NELB: They're annual, but there's a data

1 lag.

2 COMMISSIONER GORDON: Are they in every state?

3 MR. NELB: Yeah, every state has to submit it

4 annually, but there's a data lag of about four years.

5 COMMISSIONER GORDON: I don't remember doing it

6 every year, but I remember there was an extensive one while

7 I was still there.

8 MR. NELB: Yeah, because there were new rules

9 sort of requiring a more rigorous audit, 2010 or 2011 was

10 maybe the first that --

11 COMMISSIONER GORDON: Okay. Thank you.

12 CHAIR THOMPSON: Alan, were you getting in next?

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

14 COMMISSIONER WEIL: Thank you. I just want to

15 distance myself from the outrage. I think it's great you

16 pulled the curtain back, and I think there are some

17 questions that need to be answered. Kind of like with DSH

18 and lots of other issues we work with here, the

19 infrastructure of data in this system is not up to the task

20 of management. Finding another curtain to pull back and

21 finding another place is disappointing but not shocking.

22 I would hope our role, in addition to the

1 transparency and goal of improving the data, is to think
2 about this in the context of the payment issues that we
3 have discussed at some length. I think the underlying
4 policy here, again, like many in Medicaid, has some
5 conceptual basis and some practical mismatch. And so the
6 reason I want to distance myself from outrage is I would --
7 as a Commission, I would like us to be -- what was it? --
8 sober and cautious, because I don't think we know, at least
9 based on what you presented to us, I don't think we know
10 what's going on here. I don't want to sound an alarm. I
11 think it's very important we find out what's going on here,
12 but it may well be that what we find out here drives us to
13 suggest a different way of thinking about UPL, and that
14 would be a very important and exciting and challenging
15 thing to do. Like DSH, anything that looks at these
16 payment systems has potential disruption. That's where I
17 would -- so I'm holding my outrage for the time when we
18 reach a conclusion that this conceptual notion that, of
19 course, payments shouldn't exceed cost actually requires a
20 different way of thinking about it, given how much has
21 changed since some of these provisions were put in place.
22 So no desire to hold back on the goal of

1 transparency, and, again, really alarming. Don't mean to
2 minimize the alarm, but I'd rather be -- at this point I'm
3 alarmed, not outraged. Let me put it that way.
4 CHAIR THOMPSON: Toby and then Brian.
5 COMMISSIONER DOUGLAS: Following on Alan, you
6 know, I also am cautious on this, given a lot of times the
7 states as well as CMS were moving too fast, and the right
8 hand doesn't know what the left hand -- and you do one
9 process, and the next process happens, and they don't come
10 back together. And that gets to the first recommendation,
11 and, you know, clearly the goal here is to align and ensure
12 the payments don't exceed the UPL. For deference to CMS, I
13 just question whether we need to be so specific on this
14 issue of the certification and more -- the goal, again,
15 here, back to, you know, my view of things are moving too
16 fast, is that CMS in consultation with the states needs to
17 develop a process that could include or should include some
18 -- whether we use the word "certification," but ensuring
19 the UPL is complete, a complete process that ensures that
20 the payments are tied back to the UPL and reported out in a
21 transparent fashion.
22 But I just wonder, given there's also resource

1 issues here, that CMS might need state -- that we don't
2 give a little bit of -- that the recommendation leaves it
3 open on what is that process, what are all the pieces to
4 ensure we get to the end game and don't -- and ensure that
5 Kit's not outraged.
6 CHAIR THOMPSON: The other point to consider is
7 whether or not -- I don't know if CMS actually has the
8 authority to require states to certify the UPL
9 demonstrations as they've come in. And so, I mean, it's a
10 question, you know, whether that would require some kind of
11 regulatory thing. I don't know if it's a PRA issue. There
12 are always those kinds of worries. So just apropos of your
13 point about saying, you know, we need something to ensure
14 certain things happen.
15 Okay. Brian and then Sheldon.
16 COMMISSIONER BURWELL: So I assume that this may
17 turn into a chapter in June or whatever -- March, and go
18 out to the general public. I think a lot of people who
19 read this chapter will learn a lot about it, but it may --
20 you know, I think a lot of people will have the question,
21 like, "Why do we have a UPL financing mechanism for
22 hospitals at all? This doesn't make any sense to me. They

1 can just pay higher base rates."

2 Now, there are many reasons for the answer to

3 that, but I think the chapter should get into that a little

4 more. I mean, people have talked about that here, but what

5 kinds of disruption would happen in the states if the UPL

6 payment went away? My understanding is it has a lot to do

7 with where the state financing comes from. We should talk

8 about that in the report.

9 And I'm also wondering if Recommendation 2

10 includes more transparency about this financing of the

11 state's share. Do we get that data at all in state

12 reporting?

13 MR. NELB: The data is not currently part of the

14 UPL demonstrations that states submit. It is part of --

15 the Commission's prior recommendation around hospital

16 payment also included a recommendation to collect

17 information on the sources of non-federal share, but that

18 would require a new process that CMS isn't doing today.

19 CHAIR THOMPSON: So just to respond to Brian's

20 point then, we've generally made this comment that we want

21 to see more hospital-level data and we want to see that

22 come alongside of any financing information as well. So we

1 could, you know, footnote that and so forth. I mean, I do
2 think that there's room here for us in the future as we've
3 talked about, some of the points that have already been
4 made in terms of looking underneath of how good is the
5 actual data and demonstration underneath of this, and even
6 how does this accomplish this overall goal and what do we
7 think this goal is worthy. I mean, so we have more things
8 to kind of think about there. I think here we're trying to
9 clean up something that we kind of stumbled upon, right?
10 Which was in the course of collecting this for the purposes
11 of informing our larger hospital payment project, we found,
12 oh, we can't rely on this data. And so I think, you know,
13 just to remind the Commissioners, we have opportunities to
14 kind of come at some of these other questions in the
15 future. We are just trying to focus on a particular
16 problem that we've identified, which is not necessarily --
17 wasn't necessarily what we intended to identify, but
18 something that we feel needs to be rectified moving
19 forward.
20 Okay, Sheldon.
21 COMMISSIONER RETCHIN: Well, I do want to start
22 by saying I am going to remain cautious, but I'm going to

1 distance myself from sober.

2 [Laughter.]

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

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

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

1 least discussion coming back to different kinds of payment
2 reform for the safety net.
3 CHAIR THOMPSON: All right. Let me again pause
4 here for public comment before we wrap up our discussion.
5 ### **PUBLIC COMMENT**
6 * [No response.]
7 CHAIR THOMPSON: Okay. So, Rob, what I hear the
8 Commissioners suggest to you is, first, I think in terms of
9 that recommendation around the process that we reconsider
10 the use of the word "certify" and certainly lay out kind of
11 general steps in the process from state submission,
12 finalization with CMS, and then application of the
13 information by CMS and the states in both submitting and
14 certifying and allowing federal match. You will find a
15 much better way of saying that than I just said.
16 I think it sounds like we could also use -- maybe
17 take a look at the background on UPL at least to sort of
18 start to explain why -- the importance of this, why it
19 matters that states submit some of this data and look at
20 this data and what part it plays in the overall system. It
21 doesn't have to -- I don't think that has to be a lot more,
22 but I think some of that would be helpful.

1 And I also think the conversation suggests to me
2 that maybe we should explain a little bit more about this
3 discrepancy between the payments and the demonstrations and
4 possible explanations so that people can put that in
5 context, that it may be a matter of the demonstrations not
6 having all of the information, the payments may be fine.
7 And, again, sort of putting it in the context of, you know,
8 this is a set of management controls that the agency
9 instituted in order to protect itself and the states
10 against a situation where there would be a large-scale
11 disallowance that would have to happen because when you get
12 it wrong on UPL, you can get it way wrong. And then that
13 flows down to, you know, all sorts of problems for the
14 state and then the providers.
15 And so, you know, it's important to keep on top
16 of this. It's important to keep using the information
17 that's being provided. And, of course, if we ask states to
18 submit information, we should only ask them to submit
19 information that we're actually going to use. And so
20 there's a basic idea there, too, as well. I think that if
21 we can make those adjustments, we can finalize these
22 particular ones and also recognize that we have some other

1 work that we're going to ask you to continue on in the
2 context of the larger hospital payment environment and some
3 of those conversations and then maybe in the context of
4 understanding how the UPL gets calculated and whether
5 that's something that could be further refined.
6 Okay. Why don't we go ahead and look for that to
7 come back for a January votes? Thank you, Rob.
8 EXECUTIVE DIRECTOR SCHWARTZ: We're ahead.
9 CHAIR THOMPSON: We just went ahead of schedule,
10 right. We will take a break. Do you think it's bad if we
11 come back at 3:00 for managed care rules and get started a
12 little early on that?
13 EXECUTIVE DIRECTOR SCHWARTZ: I think it's okay,
14 but I wouldn't start now.
15 CHAIR THOMPSON: Yeah, okay. So we'll take a
16 break. We'll start back up at 3 o'clock on the managed
17 care rules.
18 * [Recess.]
19 CHAIR THOMPSON: Okay. Let's give it another 60
20 seconds and everyone can find their seats, finish their
21 conversations, and we'll pick up a little bit early with
22 the remainder of our afternoon agenda.

1 [Pause.]

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

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

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

10 * MS. FORBES: Okay. Thanks, Stacey.

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

19 So the federal rules for managed care oversight
20 were updated in 2016, although some parts of them do not go
21 into effect until 2017 and 2018. At the beginning of last
22 year, CMS indicated that it would be considering revisions

1 to the rule and it also allowed states to delay
2 implementation of some parts of the rule that were supposed
3 to go into effect in 2017 and 2018.
4 On November 14th, CMS published the notice of
5 proposed rulemaking, or NPRM, to amend several parts of the
6 rule. Comments are due on January 14th. CMS said, in its
7 press release accompanying the NPRM, that it had worked
8 with NAMD, the National Association of Medicaid Directors,
9 I should say, and a group of state Medicaid directors to
10 create a framework for its review. Consistent with some of
11 the issues that it had raised in its letter in 2017, saying
12 they were looking at the rule, CMS said the changes are
13 intended to promote state flexibility, particularly in rate
14 setting, network adequacy, administrative requirements, to
15 strengthen accountability for CMS and the states, and to
16 maintain an enhanced program integrity, particularly
17 regarding cost shifting to the federal government.
18 It is not a comprehensive rewrite of the rule.
19 Most of the changes are in eight areas, which I'll go over
20 quickly on the next few slides -- I'll go over briefly on
21 the next few slides. I’ll try not to be too quick.
22 So there's a memo in your background materials

1 discussing the proposed rule. The appendix has a detailed
2 summary of the proposed changes. I'm happy to answer any
3 questions if I am too brief on any of this, but I'll
4 highlight some of the main proposals here.
5 CMS has proposed changes to the rate-setting
6 rules, which it says are intended to strike a balance
7 between state flexibility and CMS responsibility to ensure
8 actuarial soundness. It reversed a provision in the
9 earlier rule and it will again allow states to use a rate
10 range instead of a specific capitation rate for each rate
11 cell, within certain parameters. It prohibits states from
12 retroactively adding or modifying risk-sharing mechanisms
13 to a contract late in a contract year or late in the state
14 budget cycle. It provides additional guidance that states
15 should follow when developing rates across different
16 populations that may receive different federal match. And
17 there are no changes to the medical loss provision.
18 Although many people were anticipating that there may be
19 changes to that, the proposed rule does not include any
20 changes to the MLR and they don't ask for comment on that.
21 The 2016 final rule added a new option for states
22 to require MCOs to direct a portion of the capitation to

1 providers under delivery system or payment reform models --
2 they're called directed payments. States use this
3 mechanism when transitioning to managed care so that they
4 can continue to make supplemental payments that otherwise
5 cannot be incorporated into managed care under actuarial
6 soundness rules. The proposed regulations here clarify
7 three types of allowable directed payments and it removes a
8 requirement for CMS review of directed payments if they're
9 using approved state plan rates, and it allows for
10 multiyear approval of certain directed payments.
11 There are also changes to the pass-through
12 payments policy. Directed payments that are not among the
13 three allowable types described above are referred to as
14 pass-through payments. In the 2016 rule, CMS clarified
15 that while supplemental payments are permissible under fee-
16 for-service rules and they created this directed payment
17 option, comparable pass-through payments are not consistent
18 with principles for actuarial soundness in managed care.
19 So it required states to either gradually phase out pass-
20 through payments within 10 years of the rule's effective
21 date, or by 2027, or convert them into directed payments.
22 CMS now proposes to allow states to make new

1 pass-through payments for services and populations
2 transitioning from fee-for-service to a managed care
3 delivery system. The new pass-through payments cannot
4 exceed the amount of supplemental payments that the state
5 was previously making under fee-for-service, and the
6 amounts must be phased out over three years.
7 There's a provision here that's not actually a
8 change. It's a request for comment. The 2016 final rule
9 provided states with additional guidance on when MCOs can
10 pay for treatment in IMDs as an in-lieu-of service. CMS
11 doesn't propose any changes but has requested public
12 comment on additional data sources that it should consider
13 to support the 15-day limit.
14 For network adequacy standards, CMS proposes to
15 eliminate the current requirement that states establish
16 time-and-distance standards for providers and instead will
17 allow states to adopt a quantitative network adequacy
18 standard. So that could be provider-to-enrollee ratios,
19 percentage of providers accepting new patients, maximum
20 appointment wait times, extended hours of operation, or so
21 on. CMS also proposes to make corresponding changes to the
22 requirements for managed long-term services and supports

1 programs. The proposed changes also clarify that states
2 can define which provider types to include in access
3 standards for specialist providers.
4 The 2016 rule required states to develop a
5 Medicaid managed care quality rating system using either a
6 CMS framework or a state-specific QRS that had comparable
7 information to the CMS framework. CMS now proposes that
8 states will be required to use a core set of measures,
9 regardless of whether they're using the CMS or state-
10 specific framework, but given that all states will now be
11 using a common set of measures CMS also proposes that
12 states won't be required to get CMS approval for developing
13 their own state-specific QRS.
14 The proposed rule makes several small changes to
15 beneficiary information requirements. These changes would
16 provide states some more flexibility in language and format
17 of information provided to enrollees, time in giving
18 enrollees notices regarding provider termination,
19 information included and timing for provider directory
20 updates, and some things like that.
21 The proposed rule makes a number of small changes
22 to the section on grievances and appeals. These provide

1 additional flexibility to states and may reduce enrollee
2 confusion. For example, the proposed rule would eliminate
3 the enrollee notice requirement for claims denied because
4 they don't meet clean claim requirements.
5 Changes to the sections on CHIP, well, there's a
6 lot of them. They appear to be primarily technical. They
7 explicitly exclude certain provisions to the managed care
8 rule, the Medicaid side, that don't apply to CHIP.
9 So there are four areas that staff have
10 identified for comment. Really, there's three and then a
11 potential answer to the question about IMD and in-lieu-of
12 services. So I think I can go through all four of them,
13 just so you can hear the whole thing, and then we can go
14 back and I can answer questions as you discuss.
15 The first is directed payments. As I mentioned a
16 few slides ago, directed payments have been allowed since
17 2016, where states can direct a portion of the capitation
18 payment to providers to further state goals under delivery
19 system or payment reform. The Commission has previously --
20 including in the last session -- raised concerns about
21 supplemental payments and fee-for-service, how the lack of
22 transparency makes it difficult to determine total payment

1 to individual providers, and how use of such payments
2 affects achievement of policy objectives such as
3 efficiency, quality, and access to necessary services.
4 Directed payments appear to account for a large
5 proportion of hospital payments in some states. Last
6 summer, we conducted a study of the development of hospital
7 payment policies in five states and found that directed
8 payments accounted for a large share of Medicaid payments
9 to hospitals. In Michigan and Mississippi, in fiscal year
10 2016, they were more than one-quarter of Medicaid hospital
11 spending and their use was growing.
12 CMS officials we spoke with also reported that
13 they've approved 85 directed payment proposals in 28
14 different states. However, we only have information from
15 our study because CMS doesn't routinely make any data on
16 directed payments publicly available. We have asked them
17 if directed payments will be included in the T-MSIS data at
18 either the aggregate or the individual provider level, and
19 CMS couldn't tell us if it would be or not.
20 It's also unclear if an upper payment limit
21 applies to directed payments and how it would be enforced.
22 As was just discussed, the UPL is intended to ensure that

1 payment to a class of providers doesn't exceed a reasonable
2 estimate of what Medicare would have paid for the same
3 service, but in managed care we can't tell if this limit is
4 being applied.
5 Finally, the directed payments policy
6 distinguishes these from pass-through payments by requiring
7 that would be tied to some state goals for quality of care
8 or outcomes under delivery system or provider payment
9 reform models, and states are supposed to have an
10 evaluation plan in place that measures the degree to which
11 these arrangements advance these state goals or objectives.
12 When we, again, got information from CMS, the most frequent
13 goal actually cited by states is to encourage access, and
14 when we talked to states last summer about how they're
15 using these payments, none of them mentioned quality as a
16 key consideration in the development of their directed
17 payment policies. So there are questions about the extent
18 to which the current requirements are being enforced.
19 So we have identified three areas for
20 consideration by the Commission that we can come back to.
21 You know, making provider level data publicly available,
22 clarifying whether the upper payment limit applies for

1 directed payments and how it would be enforced, and
2 improving the reporting and monitoring of quality
3 strategies and evaluation plans for these payments.
4 The second area includes a lot of related issues.
5 The current rule requires states making pass-through
6 payments to phase them out by 2027. The proposed rule
7 would allow states transitioning to managed care, including
8 transitioning new populations or services to managed care,
9 to make new payments for three years. CMS says that the
10 rationale for extending pass-through exception to more
11 states is to support delivery system reform by recognizing
12 the challenges associated with transitioning supplemental
13 payments into payments based on the delivery of services or
14 value-based payment structures.
15 CMS notes that since the current rule was
16 finalized in 2016, it's heard from states that would like
17 to introduce or expand managed care, but would like to
18 continue to make supplemental payments.
19 The proposed change would also account for the
20 time it takes for states to transition to value-based
21 payment structures. Our interviews last summer with states
22 and stakeholders about the development of Medicaid hospital

1 payment policies certainly reflected some more similar
2 ideas. Louisiana took about three years to convert some of
3 its DSH payments into increased base payments to providers.
4 I think Melanie had raised some concerns earlier about the
5 challenges in changing payment structures.
6 So we've noted three areas for consideration.
7 First, the Commission may want to comment on the proposal
8 to extend the use of pass-through payments at all, whether
9 this is -- right now there are existing payments that were
10 grandfathered in and must be phased out, this would create
11 a new option for this. And, in particular, whether the
12 ability to make pass-through payments should be extended to
13 states beyond those grandfathered in by the 2016 rule.
14 This would include states that want to transition new
15 services or populations to managed care.
16 If the Commission supports the extension of the
17 pass-through option, MACPAC could make two suggestions to
18 mitigate its concerns regarding supplemental payments.
19 These are similar to the concerns with directed payments --
20 the challenge of determining total payment to individual
21 providers and the effect of lump-sum payments on efforts to
22 transition to value-based purchasing methods.

1 And then the third area for potential comment:
2 the 2016 rule requires states to implement time and
3 distance standards for specific provider types. Those went
4 into effect, as I said this morning, in July of 2018. We
5 talked about it this morning. The NPRM would require
6 states to adopt a quantitative standard of their choosing.
7 States could use different standards for different provider
8 types or different parts of the states. States would not
9 have to use a standard with a geographic or distance
10 component.

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

19 Using at least one national standard -- although
20 states are allowed to develop their own benchmarks, but
21 they all have the same standard, which is time and distance
22 -- allows states and other stakeholders to compare network

1 adequacy measure across states. Moving to a mix of
2 quantitative standards would make it harder to determine
3 whether any state benchmark is appropriate because each
4 state could be using not only its own benchmarks but its
5 own mix of standards and measures.

6 And finally, this area of in-lieu-of payments for
7 IMDs. The proposed rule again does not propose any changes
8 to this provision. CMS noted that it could not identify
9 new data sources other than those that they relied upon in
10 2016, which proposed a 15-day limit, and requested public
11 comment on additional data sources that it should consider.

12 There are additional data sources, ones that CMS
13 could consider when assessing this provision, and if MACPAC
14 submits a comment letter it could include this information.
15 For example, the 21st Century Cures Act requires HHS to
16 study the effects of the 15-day in-lieu-of provision and
17 issue a report at the end of next year, and that report
18 must address a number of things, including the range of and
19 average number of months and the length of stay during
20 those months for beneficiaries receiving services in IMDs.
21 A second data source would be data available through
22 approved Section 1115 substance use disorder

1 demonstrations. As of last month, 18 states had approved
2 Section 1115 demos to cover SUD services in IMD settings.
3 So we could certainly point those data sources out.
4 So before you discuss the potential areas for
5 comment I do want to note that in the memo staff raised a
6 couple of technical questions which we could include in a
7 comment letter, if you choose to submit one, unless you
8 object to them or want to change any of those technical
9 issues. Comments on the proposed rule must be submitted by
10 January 14th, which is prior to the next Commission meeting
11 on January 24th. So this is your only opportunity to
12 discuss your input on the proposed changes in public.
13 Should the Commission decide to comment on any of the areas
14 outlined above, or on other proposed areas of the rule, we
15 can prepare a letter that reflects the discussion at this
16 meeting. And you may also want to think about whether the
17 changes or the concepts described in the NPRM suggest any
18 other areas that you'd like staff to work on, going
19 forward.
20 VICE CHAIR LAMPKIN: Thanks a lot, Moira. I have
21 a couple of question and maybe a request for a little more
22 elaboration on a couple of points. Looking back at

1 MACPAC's comments on the proposed version of the original
2 rule, one of the things that we expressed a concern about
3 was the administrative burden and the challenges that
4 states might have in implementing some of the provisions of
5 the proposed rule. And it sounds like at least CMS's
6 intent with these proposed revisions now are to address
7 administrative burden and state flexibility. That's a
8 correct understanding?

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

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

16 MS. FORBES: It was -- I'm trying to think. I
17 mean, we went through it. It was difficult to assess the
18 change in burden. I mean, states are already doing a lot
19 of things and these would make some things optional. And
20 in some places there is less flexibility. I mean, there is
21 a mix in the rule and in some places there is more
22 flexibility and in some places there is less. So it's a

1 little hard to say what the net effect would be. It would
2 probably depend on what choices a state makes, in terms of
3 if they decide to go forward with certain options.
4 VICE CHAIR LAMPKIN: Okay. And the request for a
5 little bit more elaboration or clarification. I think if
6 we go back to Slide 6 you were talking about directed
7 payments. And was this the slide where you talked about
8 how many, preprint, CMS had approved with respect to
9 different kinds of directed payments in a couple of states,
10 Mississippi being one of them, I think? Can you remind us
11 kind of what types of payments are falling under this
12 directed payment category versus the pass-through, which is
13 treated as a separate category and discussed differently?
14 MS. FORBES: Sure. No.
15 [Laughter.]
16 VICE CHAIR LAMPKIN: This is, I think, value-
17 based purchasing.
18 MS. FORBES: It's value-based payments that can
19 direct that you are making a value-based payment, that
20 you're making an add-on payment, or that you're paying
21 state -- that you're requiring them to pay state plan
22 rates.

1 VICE CHAIR LAMPKIN: A specified maximum fee
2 schedule --
3 MS. FORBES: Yes. That you're paying --
4 VICE CHAIR LAMPKIN: -- or a minimum fee
5 schedule.
6 MS. FORBES: -- yeah, so that you're paying
7 commercial or Medicare rates.
8 VICE CHAIR LAMPKIN: Yeah, or -- and I think
9 there's a multi-payer delivery system reform --
10 MS. FORBES: If you're participating in it, yes.
11 VICE CHAIR LAMPKIN: -- that comes under this
12 too. So I'm just trying -- I think it's helpful to name
13 the kind of range of types of payments we're talking about
14 as we think about the proposed -- like your question about
15 should UPL apply to this. It's helpful to think what types
16 of payments actually come under this category.
17 MS. FORBES: Mm-hmm.
18 CHAIR THOMPSON: Can I ask a UPL-related question
19 while you're in that neighborhood?
20 VICE CHAIR LAMPKIN: Yeah.
21 CHAIR THOMPSON: I was slightly confused by the
22 reference to UPL, because I think of UPL as that's fee-for-

1 service. Actuarial soundness, that's managed care. So is
2 the question that we're asking whether payments that would
3 have been made under the UPL, because they were fee-for-
4 service, when converted into a directed payment under
5 managed care, do they still need to be subject to the UPL?
6 I mean, that seemed a little confusing to me, because it
7 seems like the rule is setting an outside boundary for what
8 can be brought over into managed care, and once it's
9 brought into managed care it's subject to actuarial
10 soundness. Correct?
11 MS. FORBES: Yes. Rob, did you have anything to
12 add on that?
13 MR. NELB: [Speaking off microphone.]
14 CHAIR THOMPSON: Rob is very reluctant to come
15 and talk more about the UPL.
16 MR. NELB: If you didn't get enough on UPL. So,
17 yeah, you're right that actuarial soundness determines the
18 limit on the overall capitation rate. A question, right,
19 is if you did that directed payment option that's
20 increasing rate to a provider, whether you could allow
21 those providers to get paid more than what Medicare would
22 have paid, or if there's any sort of limit on how high you

1 can go up for that particular provider classes, or whether
2 you just want to keep the limit with actuarial soundness as
3 it applies now, which is for the entire set of services
4 included under the managed care contract.
5 CHAIR THOMPSON: Right, although now UPL isn't
6 applied at the provider-specific level, but rather at --
7 MR. NELB: Correct, but for a class of providers.
8 CHAIR THOMPSON: Right. Okay.
9 VICE CHAIR LAMPKIN: So thank you for letting us
10 talk through the reminders, because I, too, was, like
11 Penny, I was a little puzzled by that -- some of those
12 suggested areas for comment around directed payments. You
13 know, do we know what CMS is seeing in the preprints, in
14 terms of the proportion of them that are specified fee
15 schedules versus some of the more creative things like
16 multi-payer delivery system reform or value-based
17 purchasing?
18 MS. FORBES: I can look back in the preamble. I
19 can't remember what they said. We can look back in the
20 preamble and see how much of that they might have
21 summarized.
22 My sense is that a lot -- part of the reason they

1 put the exception in for a state plan was because a lot of
2 states had done that.
3 VICE CHAIR LAMPKIN: Yeah. And I'm not trying to
4 put you on the spot. In the bits and pieces that I'm
5 seeing come through, it tends to be a fixed fee schedule
6 kind of dynamic, where it's very often the state plan fee
7 schedule that is at target. So, to me, that exemption
8 makes a lot of sense, but I didn't know if there was
9 perhaps more of the other types that make some of these
10 other comments perhaps more important. So thank you.
11 I'll just say one more thing and then definitely
12 want to solicit other's feedback. I was actually a little
13 surprised that perhaps a narrower scope of revisions than I
14 had imagined might be coming. A lot of what CMS has
15 proposed makes sense to me based on the way we've seen the
16 rule roll out. So I thought that was interesting.
17 Do others have comments or questions?
18 COMMISSIONER CERISE: I have a question, I
19 suppose. When you mention that the directed payments are
20 the primary reason a site was accessed, is there any
21 expectation that would go into what that is actually
22 addressing?

1 We talked earlier about gaps in access and how
2 you really get at what the access issues are, and I'm
3 wondering if we shouldn't ask for some more clarification
4 about just general access, which is sort of the
5 responsibility of the managed care organization to do with
6 the actuarially based rates that you have, or you're
7 talking about access to some pockets of specialty care,
8 some other services. What else is getting lumped in there
9 that you're trying to preserve or achieve? Do you know
10 what I'm saying?

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

22 Then in terms of the accountability for those

1 payments, you mentioned examining the amounts, who they're
2 being made to, and again, not to sound like a broken
3 record, but it would be interesting to see that, again, net
4 of IGT or provider taxes or things like that, so you can
5 see what payments are actually going to support what
6 providers.

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

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

20 VICE CHAIR LAMPKIN: Yeah. And so is some of
21 that in the preprint? Because there has to be a linkage to
22 the quality strategy for the directed payments.

1 MS. FORBES: So our research on the evaluation
2 plans was from -- we didn't look at those. Someone else
3 looked at them. We were looking at the literature on that,
4 so we'd have to go back and try and dig some up.
5 COMMISSIONER CERISE: I just note you mentioned
6 that none of the interviewees in your study mentioned
7 quality as their key consideration, but access was the
8 heavily mentioned thing. What special piece of access are
9 we getting with more directed payments?
10 VICE CHAIR LAMPKIN: So are you suggesting, Fred,
11 that there is a comment that we make to the proposed
12 revisions related to that?
13 COMMISSIONER CERISE: I mean, I think it would be
14 worth kind of probing. It's such a general category for
15 the payment.
16 VICE CHAIR LAMPKIN: Okay. Do we expect that --
17 or, Moira, do we know whether the MCOs will have to report,
18 through encounter data, the payments made for all these
19 directed payments? The minimum fee schedule, maximum fee
20 schedule type, I'm sure would come through encounter data,
21 but some of the other kinds?
22 MS. FORBES: I don't know about encounter data.

1 We asked about the T-MSIS reporting and couldn't get an
2 answer on that. I don't know what states are requiring for
3 encounter data.
4 VICE CHAIR LAMPKIN: Okay.
5 MS. FORBES: We asked -- I mean, states have been
6 making these already, so we asked to see if they were
7 coming through already and couldn't get an answer on that.
8 VICE CHAIR LAMPKIN: Did you have something,
9 Darin?
10 COMMISSIONER GORDON: So, first, I will say I was
11 asked, my experience running a managed care program, on my
12 thoughts on a variety of state-specific concerns with the
13 managed care regs. I wasn't involved in any decision-
14 making or the writing of the rule, but I'll just say that
15 as a disclaimer.
16 On this particular issue -- and this is all just
17 based on the documents in our binder, but the three areas
18 that they clarified -- adopt a minimum and maximum fee
19 schedule -- I remember having this discussion back when I
20 was in Tennessee. It was like we were actually directing
21 that our hospitals cannot be paid over 100 percent of
22 Medicare, and it was prohibited under the other managed

1 care. I could not direct that.

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

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

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

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

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

22 So separate the supplemental payments. Set those

1 aside. If you look at these three categories, I could see
2 if every one of these would be capturing encounter.
3 And to your point on quality, I'm assuming that's
4 tied to your value-based purchasing models. Your other
5 ones -- when we would do increases, our legislature would
6 require an increase per providers. That was a rate
7 increase across providers that we would want to be able to
8 dictate. So the plans just didn't get it built in their
9 rate, and it didn't pass through. It was with the intent
10 of keeping access in the delivery system.
11 So I think -- and, again, I'm speculating on
12 things, but I know NAMD had written a long letter of here
13 were their concerns, and I know these types of things were
14 in that list. And that might be where some of the comments
15 around access were articulated.
16 And, again, I can see in the first couple how
17 that did apply in our case in Tennessee.
18 CHAIR THOMPSON: I'll just follow up. First of
19 all, I agree with Darin. I think we need to be sure that
20 as we're looking at the conversation on directed payments,
21 we're being really clear about what the rule is proposing
22 to change or not change with respect to that because I

1 think there is definitely aspects of that, that seem like
2 they're just avoiding a lot of interaction between the
3 state and federal government over things that are pro
4 forma.
5 I do think that the point about not -- certainly
6 not losing any transparency that we currently have and
7 continuing to promote transparency on directed payments and
8 supplement payments, wherever they're made, whether in
9 managed care or fee-for-service is consistent with ongoing
10 conversations and prior recommendations of this Commission.
11 And that's something that I think we should just say as a
12 general matter.
13 On the additional opportunity to make pass-
14 through payments, it would be interesting to see if in the
15 public comment, we have any further observations on this.
16 But it's my experience that one of the things that has
17 happened before is that states have not wanted to go to
18 comprehensive managed care because they needed to retain a
19 fee-for-service payment structure in order to support
20 supplemental payments that they needed to make, and I think
21 that's what this is trying to address. And if I've got
22 that right, I think it's a good thing to try to address

1 that and to take away a bad incentive to maintain a fee-
2 for-service structure just because you have no other way of
3 ensuring that some of your safety net providers can be
4 continued to be supported or that you received the
5 financing that you're looking for to continue the program.
6 So I actually think if I've got it right about
7 the purpose of that provision, I think that's actually a
8 very good thing.
9 Those are payments that were already being made
10 in fee-for-service, so it's not like the program is
11 absorbing a new cost. It's simply allowing those costs to
12 get transferred over into that new system.
13 Under a phase-down, I do think that your point
14 about considering a phase-down in pieces is one worth
15 putting out there, but I'm not sure that we have enough
16 information to know whether or not that's the way that it
17 should happen or not.
18 So maybe I would -- I take it back. Maybe I
19 would say let's not go there unless we have a strong sense
20 that that's the way that it needs to kind of continue to
21 cut down. I'm not sure of that, especially in three years.
22 If you had a ten-year period or maybe a seven-year period,

1 you would want to see a systematic reduction over time, but
2 in three years, I think you could come up with different
3 ways of doing that, that would all be okay.
4 I think wherever we have information that we
5 should provide it.
6 I was interested in the earlier conversation
7 about adequacy about people's feelings about time and
8 distance. So I'm not sure what to suggest.
9 That we say there when you said, well, everybody
10 is using time and distance now, so everybody is meeting the
11 federal requirement now can be an argument that cuts both
12 ways, which is, well, then you don't need a federal
13 regulation to say it because everybody is just doing it.
14 That's just standard practice. Or are they doing it
15 because -- in other words, there's a little bit of a -- if
16 everyone is doing it, then is it important to keep that in
17 the rules?
18 I heard a lot of Commissioners talk about the
19 limits of a time and distance standard for really giving
20 you insight into where you stand with access, so maybe
21 that's something other Commissioners could chime in on.
22 COMMISSIONER GORDON: I agree. It does beg the

1 question if everyone is doing it, does it prohibit it, and
2 I think as we had the discussion earlier, it's more complex
3 than that. That that standard, in essence, is
4 insufficient, and they're not saying you can't do it.
5 States can use that, but they're saying you should have
6 some quantitative standard.
7 EXECUTIVE DIRECTOR SCHWARTZ: I think in the
8 earlier conversation, though, we said all states were doing
9 it -- of the states you reviewed, states were doing
10 multiple other things as well. So the existence of the
11 time and distance standard didn't prevent them from doing
12 other things.
13 I don't know, Moira -- that they're doing the
14 time and distance standard because that's what's required
15 to do.
16 MS. FORBES: In the 2016 rule, in the preamble,
17 CMS noted that part of the reason it had settled on time
18 and distance was because most states were doing time and
19 distance then.
20 CHAIR THOMPSON: That's a little bit of a chicken
21 and the egg kind of situation.
22 COMMISSIONER GORDON: I will say I don't know if

1 it -- and I'm just speculating here as to whether or not
2 that had something to do with -- if that's all I say is the
3 standard, is that endorsing that as being a sufficient
4 standard versus the fact that really the reality is I think
5 most people who have gotten into it acknowledge that it's
6 not.

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

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

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

21 MS. FORBES: The current rule says that the state
22 quality strategy needs to include the network standards,

1 and the state quality strategy has to include a public
2 review. It has to be --include that. I'm not exactly sure
3 how the public is supposed to be involved, but there's a
4 draft and a final and the CMS review.
5 CHAIR THOMPSON: Maybe that's just something that
6 we could note that we think is -- in providing this kind of
7 additional flexibility, that we note the importance that we
8 would attach to that being part of -- an important part of
9 the conversation that's taking place with stakeholders in
10 devising the strategies.
11 VICE CHAIR LAMPKIN: Anything else on network
12 adequacy?
13 [No response.]
14 VICE CHAIR LAMPKIN: Any comments on the IMD
15 changes or request for other data sources? We can flip to
16 that next slide.
17 I think Moira had called out we could make a
18 comment about a couple of other data sources, the 1115, the
19 SUD waivers. Do people feel that these comments are
20 important for us to make? Any opinions?
21 [No response.]
22 VICE CHAIR LAMPKIN: So maybe we could take a

1 break from our discussion and hear any public comment or
2 feedback on these proposed revisions and get that
3 perspective in front of the Commission. Do we have any
4 members of the public who would like to comment?
5 **### PUBLIC COMMENT**
6 * [No response.]
7 VICE CHAIR LAMPKIN: Okay. So hearing none, it's
8 not -- I'm not sure that I have a sense of the Commission
9 about whether we feel strongly about providing a comment
10 letter. I've heard some pieces like, well, we could stress
11 the importance of continued transparency. That's been
12 important to us before. We could stress the importance of
13 public input into the network adequacy standards. Do we
14 have enough reaction to these proposed changes that we want
15 to submit a comment letter and what are the major feedback
16 that we would provide?
17 CHAIR THOMPSON: I think we should provide a
18 letter. I think there's various pieces of information or
19 observations, but I do think that, in general, I don't see
20 -- and this is myself, and I'm not hearing from the other
21 Commissioners -- a lot of points of serious concern,
22 objection, and so that we ought to be generally expressing

1 the view that the changes are -- I think, Stacey, you
2 describe them as kind of within a reasonable range of
3 decisions that you could land on and hear their -- you
4 know, I think there's things for us to continue to make
5 sure that we draw the agency's attention to, but not with
6 respect to any particular, in my mind, suggestions about
7 changes, other than perhaps to reaffirm the desire to see
8 some of this provider-specific data continue to be a point
9 of contention.
10 VICE CHAIR LAMPKIN: And then, Moira, you said
11 there's some technical comments that would be included in
12 the comment letter.
13 MS. FORBES: That was around whether or not DSH
14 would be included and some of the definitions. There was
15 like one small thing in there.
16 CHAIR THOMPSON: Martha's turn.
17 VICE CHAIR LAMPKIN: Oh, yeah. Sorry, Martha.
18 COMMISSIONER CARTER: So I'm having a semantic
19 problem here. So CMS is asking for additional data sources
20 to support their 15-day limit, not whether the 15-day limit
21 is appropriate or not? That's what I thought I read.
22 Okay. Is there anything -- and you think that we

1 could provide some additional data sources?

2 MS. FORBES: Yes. I mean, those are additional

3 data sources.

4 COMMISSIONER CARTER: If we chose to do a

5 comment, that we would include.

6 MS. FORBES: Mm-hmm.

7 COMMISSIONER CARTER: That seems reasonable.

8 VICE CHAIR LAMPKIN: Okay. Thanks, everybody.

9 Next up, another proposed rule.

10 Kirstin and Kristal.

11 **### REVIEW OF PROPOSED RULE AFFECTING INTEGRATED CARE**

12 **FOR DUALLY ELIGIBLE BENEFICIARIES**

13 * MS. VARDAMAN: Good afternoon, Commissioners.

14 We're going to end today with an overview of another

15 proposed rule.

16 On November 1st, CMS published a proposed rule

17 with policy and technical changes related to Medicare

18 Advantage and Part D. Our presentation today will focus on

19 proposed changes regarding Medicare Advantage dual-eligible

20 special needs plans, or D-SNPs. These proposals would

21 implement provisions of the Bipartisan Budget Act of 2018,

22 which was enacted in February of this year. The Bipartisan

1 Budget Act established new requirements that D-SNPs must
2 meet by plan year 2021. I will discuss the ways in which
3 CMS proposes to implement new requirements regarding the
4 integration of Medicare and Medicaid benefits, and then
5 Kirstin will discuss the unification of grievance and
6 appeals procedures.
7 As we reviewed the proposed rule, we found it to
8 be straightforward in its implementation of the BBA
9 requirements. The proposed new minimum integration
10 standards, which we will discuss shortly, seem to be in
11 agreement with the Commission's interest in using
12 integrated care to improve beneficiaries' care experiences.
13 Similarly, the procedures proposed to unify grievance and
14 appeals processes seem reasonable given the Commission's
15 past work in this area.
16 Given our assessment of the rule, we do not have
17 any suggestions for areas for comments; however, in the
18 course of your discussion, if the Commission identifies
19 areas where it would like to provide comments, we can
20 certainly draft a comment letter. The deadline to submit
21 comments on this proposed rule is the end of this year.
22 BBA 2018 mandated that D-SNPs meet one or more of

1 three requirements regarding the integration of Medicare
2 and Medicaid benefits. I'll walk through each of them in
3 the next few slides.
4 First, the BBA said that a D-SNP must, in
5 addition to meeting existing requirements of contracting
6 with the State Medicaid agency, meet an additional minimum
7 set of requirements for integration established by the
8 Secretary based on input from stakeholders. CMS proposes
9 to implement this provision by requiring that D-SNPs notify
10 the Medicaid agency or a designee of hospital and skilled
11 nursing facility admissions for at least one group of high-
12 risk, full-benefit dually eligible beneficiaries as
13 determined by the state Medicaid agency.
14 This requirement would apply to D-SNPs that are
15 not fully integrated dual-eligible special needs plans, or
16 FIDE-SNPs, or that do not provide long-term services and
17 supports or behavioral health services under capitated
18 arrangements. Such D-SNPs are covered under other options
19 that we'll discuss soon.
20 CMS's rationale for this proposal is that these
21 notifications could be used to improve care transitions.
22 Improved communication could promote better transitions of

1 care into the setting of a beneficiary's choice. For
2 example, if states are promptly notified of hospital or
3 skilled nursing facility admissions, they could connect
4 beneficiaries with opportunities to receive home and
5 community-based services, or HCBS, following discharge.
6 Under this proposal, states would select the
7 subpopulations requiring D-SNP attention. For example, a
8 state might define a high-risk population as all
9 individuals using HCBS. Alternatively, states could use
10 claims or encounter data to target certain high-risk
11 individuals such as those with a history of hospital
12 readmissions or who are high users of certain services.
13 The proposed rule acknowledges that states are
14 not all similarly positioned and provides flexibility in
15 how states implement this requirement. States would
16 establish their own notification procedures and protocols,
17 time frames, and method of notification. CMS notes that
18 states may choose to expand requirements as processes and
19 infrastructure mature over time.
20 Under the second BBA option, D-SNPs can either
21 meet most of the requirements of FIDE-SNPs or enter into a
22 capitated contract with the state Medicaid agency to

1 provide long-term services and supports, or LTSS,
2 behavioral health services, or both. To implement this
3 provision, CMS proposes to define a new category of D-SNPs,
4 referred to as highly integrated dual-eligible special
5 needs plans, or HIDE-SNPs.

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

20 The BBA specified that for 2021 through 2025 the
21 Secretary could impose a sanction for D-SNPs that do not
22 meet the new integration requirements, which is what CMS

1 proposes in this rule. CMS proposes to prevent a D-SNP
2 from enrolling new members if it does not meet the new
3 integration requirements. The agency interprets this
4 enrollment sanction as a lesser penalty than a contract or
5 plan termination while D-SNPs transition to the new
6 requirements. While sanctioned D-SNPs could not enroll new
7 members, such a sanction would not disrupt care for
8 previously enrolled beneficiaries.
9 And now I will turn it over to Kirstin.
10 * MS. BLOM: Thank you, Kristal. Good afternoon,
11 Commissioners. Now we'll turn to appeals and grievances,
12 which we've talked about before.
13 So BBA requires that the Secretary establish a
14 unified process for enrollees in D-SNPs to the extent that
15 that's feasible. That's important because CMS decided that
16 it's most feasible for a subset of D-SNPs that have this
17 exclusive alignment that Kristal talked about. Just to
18 reiterate, that's where one plan is responsible for both
19 Medicare and Medicaid coverage and the parent organization
20 is the same across the D-SNP and the MCO. CMS set it up
21 this way because they believe that this is the way that
22 it's most feasible to manage the process under one entity.

1 CMS estimates that this will affect about 37 plans, 37 D-
2 SNPs in eight states, which is about 7 percent of
3 enrollees.
4 Because procedures are only going to be unified
5 for a subset of D-SNPs under this proposed rule, that does
6 mean that requirements for other D-SNPs won't change, and
7 if the rule was to become final, there would now be
8 different requirements for this subset versus all other D-
9 SNPs.
10 CMS is also proposing to align the processes only
11 at the health plan level, and this is due to challenges
12 that occur in going beyond that level, which I'll talk
13 about in a little bit. Aligning at this first level, the
14 health plan level, establishes a single entity, the health
15 plan, which beneficiaries can use to process their appeal.
16 This is consistent with what most states have done under
17 the Financial Alignment Initiative. Only one state in the
18 duals demos went beyond the health plan level, and that was
19 New York, which created a fully integrated process.
20 Some of the key elements of the proposed unified
21 process for this subset of D-SNPs that are particularly
22 relevant to Medicaid include requiring that D-SNPs assist

1 their enrollees with their Medicaid coverage issues,
2 including helping them file appeals, also maintaining state
3 flexibility, which is consistent with current law, where
4 standards might be set in regulation but then states have
5 the option to provide additional beneficiary protections.
6 For example, time frames are often set in regulation at a
7 certain minimum. For example, 30 days is the requirement
8 for resolving an appeal, but states choose to make that a
9 shorter time frame to provide additional protection for the
10 beneficiary such as in Ohio where it is limited to 15 days.
11 CMS also adopted Medicaid's continuation of
12 benefits provision. This is a provision that's unique to
13 Medicaid, it does not occur in Medicare. Under the
14 proposed rule, that means that beneficiaries in these
15 subsets of D-SNPs would be able to continue receiving
16 Medicare and Medicaid benefits while their appeal is
17 pending.
18 Interestingly, CMS does estimate a fairly minimal
19 impact on Medicare spending as a result of this provision
20 because in their estimation most Medicare benefits are not
21 continuing. Either they have already been provided, such
22 as emergency service benefits, or they're subject to

1 immediate review rights under Medicare, whereas, for
2 example, with inpatient hospital services a beneficiary has
3 the right to demand -- to request an immediate review of a
4 denial of those benefits.

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

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

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

1 be replicated nationally.

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

12 Another challenge is around state flexibility and
13 the potential constraints on it as a result of the
14 additional rulemaking that would probably be necessary for
15 a fully unified process. CMS believes that a fully
16 integrated process should be optional for states rather
17 than a national requirement. And states obviously
18 administer their programs very differently. That's
19 something that we as the federal government have encouraged
20 them to do. But in a situation where CMS is creating a
21 fully unified process, there would probably be specific
22 rulemaking required in that arrangement that would then

1 constrain the kinds of options that states have come to
2 know and take advantage of.
3 So with that, we're happy to take any questions
4 you have. We felt this was, as Kristal said at the outset,
5 a fairly reasonable approach to the rule, so we're happy to
6 hear your thoughts.
7 VICE CHAIR LAMPKIN: Thank you, Kirstin and
8 Kristal. You can go first, Melanie.
9 COMMISSIONER BELLA: Thank you both very much. I
10 have a comment on each piece of it.
11 I guess on the grievances and appeals, I
12 understand why CMS would start where it starts. I don't
13 understand why some more states aren't in the list of
14 exclusively enrolled, like Pennsylvania or Arizona, but
15 whatever, that's an aside. I would encourage, though, they
16 could -- when I was at CMS and we did that in New York, it
17 was with the intent to learn from New York and then expand
18 that to the other demonstration states, too. So in
19 addition to doing it in these states, they could actually
20 extend it to the other demonstrations in the Financial
21 Alignment program as well, and I think that might be worth
22 mentioning.

1 CHAIR THOMPSON: So you're saying that we ought
2 to encourage them administratively to continue to get more
3 people into the world of trying to build that fully
4 integrated system rather than through a rulemaking.
5 COMMISSIONER BELLA: I'm just saying -- so in all
6 of the other demonstration states, they didn't go as far as
7 New York, and so they could take all the other
8 demonstration states to New York in addition to doing it in
9 these other exclusive enrollment states that they're
10 talking about. Does that make sense?
11 One of the big sticking points was Part D. Part
12 D was a really big one to figure out, and that was the
13 hardest part for Medicare to sort of delegate to this
14 function in New York. But even though they're small
15 numbers -- and you were kind in how you described the size
16 of the FIDA demo -- I do think that there's enough that
17 went into it that there's a lot to learn from how we even
18 got the Medicare folks to be comfortable with this, as well
19 as the advocates. And so I think there's probably a lot to
20 learn, even if there's not a lot of experience of people
21 actually going through the system.
22 On the other points, there's been a little bit of

1 grumbling from states about the reporting piece for the
2 states that will have to go through the hospital reporting
3 thing. I don't know that it's worth us commenting on. I
4 guess my comment would be I would like to see us, even if
5 it's making a small statement, make a statement to the
6 agency indicating that we support this move toward
7 alignment and, you know, we keep raising the bar. But I
8 want to hit again on this thing about look-alikes. More
9 information is coming out about the look-alikes. It looks
10 like in 2019 there will be 40 states with look-alikes, and
11 if the look-alikes -- again, just to remind folks, to be a
12 dual-eligible special needs plan, you have to have an
13 agreement with the state Medicaid agency. If you can't get
14 that agreement -- and some states are saying, "I'm going to
15 try to line up my Medicaid managed care plan with my
16 Medicare D-SNP," to get a -- you have to win a Medicaid
17 bid, and the state says you also have to be a Medicare D-
18 SNP, and they line that up. And they won't give MIPPA
19 agreements outside of that because they want people to go
20 into an aligned product.
21 The plans that can't get in, that's one of the
22 reasons they've become this look-alike. They can't get a

1 D-SNP agreement from the state, so they go in as a plain
2 vanilla Medicare Advantage plan. They don't have to comply
3 with any of the model of care rules. They market to duals,
4 and the brokers are aggressive about it. And so I just
5 think it's -- the agency is asking for people to let the
6 agency know that this is an issue that people are concerned
7 about with regard to the possibility of the undermined
8 integration, and I think this would be an opportunity, even
9 if it's just a couple sentences, to say as we continue to
10 support the move toward integration, please be wary of this
11 explosive growth -- we don't have to use "explosive" -- in
12 look-alikes. We understand you don't feel like you have
13 any authority there, but we encourage you to keep an eye on
14 it because it's going to undermine all these things that
15 you've nicely set out in this rule. So I would put a plug
16 in for that.
17 CHAIR THOMPSON: I agree with that.
18 VICE CHAIR LAMPKIN: Toby.
19 COMMISSIONER DOUGLAS: I would just add to what
20 Melanie said. I don't think it -- I think it's important
21 just to add to that point on the look-alikes, is that to
22 the extent we strengthen the requirements of D-SNP, it's

1 going to push more plans to go in that direction, saying,
2 okay, I don't want to have to do this, I'll just go around
3 it with a look-alike. So they can't -- I fully support
4 these changes, but it has to be done in concert with
5 preventing those plans from moving around it.
6 VICE CHAIR LAMPKIN: Okay. Brian.
7 COMMISSIONER BURWELL: So I agree with everything
8 Melanie said. On the first provisions, in terms of how
9 this is operationalized, it looks to me like there has to -
10 - there's a state decision. This isn't just -- the D-SNPs
11 have to do one of these three things in order to maintain
12 their status as a D-SNP, correct? But the decision about
13 which of the three is required seems to be more of a state
14 decision that then would get incorporated into the MIPPA
15 agreement, like reporting to the state about hospital or
16 nursing home admission. You know, so to me it's a two-
17 sided or a two-pronged policy decision around the
18 implementation of this rule. Is that your perception as
19 well?
20 COMMISSIONER BELLA: Yeah, I mean, the states
21 have already sort of picked their delivery system vehicle,
22 and so I think, yeah, they are going to have variations on

1 this. And this is why also, though, it is legitimately a
2 problem for D-SNPs that want to operate in states that kind
3 of won't do any of these things.
4 COMMISSIONER BURWELL: Right.
5 COMMISSIONER BELLA: So that's just an issue, I
6 think, that needs to get addressed outside of this. But,
7 yeah, I mean, the state is already deciding, though, do I
8 want to capitate, fully capitate, do I not? If not, then
9 we'll offer the opportunity to do the data sharing. But
10 it's --
11 COMMISSIONER BURWELL: Yeah, my question is more
12 -- so the D-SNP has to do one of these three things. Is
13 that correct?
14 COMMISSIONER BELLA: Right.
15 COMMISSIONER BURWELL: So before it can make that
16 decision, it has to go to the state and go, Which one do
17 you pick?
18 COMMISSIONER BELLA: Yeah, I mean, the D-SNPs
19 already have -- most of them already have -- they either
20 have a contract for the capitated contract with the
21 behavioral health and long-term care, or they don't, or
22 they're in a state that -- what?

1 COMMISSIONER GORDON: Or [off microphone].
2 COMMISSIONER BELLA: Yeah, but you can't just
3 have a MIPPA anymore.
4 COMMISSIONER GORDON: I'm saying there's a
5 process. Every D-SNP is going through and interacting with
6 the state, and the state is setting out its expectations in
7 a MIPPA agreement. Now, some actually have more robust
8 expectations than others, but I'm just saying there's
9 always that interaction at that point if the state has, to
10 your point, policy goals or objectives they can insert that
11 in the MIPPA agreement.
12 COMMISSIONER BURWELL: Okay.
13 COMMISSIONER GORDON: In other words, they are
14 already having to talk to the state, basically.
15 COMMISSIONER BURWELL: Well, it would also be the
16 document by which the D-SNP would go straight to CMS that
17 it has met this requirement is that here's our MIPPA
18 agreement and we are doing this under our MIPAA agreement
19 currently.
20 VICE CHAIR LAMPKIN: Okay. Penny.
21 CHAIR THOMPSON: So I agree as well with
22 everything that's been said. I think we should write a

1 letter that is supportive of the rules and the approach
2 they've taken. One thing I've just not heard mentioned, I
3 was just really glad to see them continue the protections
4 that are afforded generally through Medicaid, as they think
5 about unifying. And I think calling that out, that's
6 always been a bit of rub, and I'm just really glad about
7 where they've landed with respect to those issues.
8 COMMISSIONER BELLA: I'll just add onto that. I
9 think we should specifically call out Aid Paid Pending,
10 even though they minimize that.
11 CHAIR THOMPSON: That's right.
12 COMMISSIONER BELLA: I think we should highlight
13 that --
14 CHAIR THOMPSON: That's a big deal.
15 COMMISSIONER BELLA: -- as a very positive thing
16 that that you wouldn't get in just regular Medicare today.
17 VICE CHAIR LAMPKIN: Other comments? Do we have
18 public comments on this rule, on this proposed rule?
19 ### **PUBLIC COMMENT**
20 * MS. DOBSON: I can't resist. I'm sorry.
21 Hi. Camille Dobson. I'm Deputy Executive
22 Director at NASUAD. We represent the aging and disability

1 directors who deliver LTSS. We are in the middle of
2 reviewing the reg ourselves and sending it out to the
3 states, and we found a number of places where the NPRM
4 asked for comment and feedback from the states. So a couple
5 of things.
6 We are also very glad, I think, to see Aid Paid
7 Pending. It's been a problem for our states. They're also
8 worried, Melanie, about lookalikes coming in and
9 undermining especially those states that have made a real
10 effort in their MLTSS program to do exclusive alignment.
11 And what we are hearing is that they would like Medicare to
12 be more active in putting some guardrails around. So I
13 think that's probably what we will say in our comments. I
14 don't know. I always wait to -- somebody always says
15 something that I don't expect when we send it out for
16 review to our members.
17 And then the other thing that I didn't pick up,
18 and I want to make sure maybe if Kirstin found this. I
19 thought we read a piece that does not allow the state or
20 the SNP to go -- to recover services once they've been
21 delivered Aid Paid Pending. At least that's how we read
22 it, that regardless of whether Medicaid allows, like has a

1 rule that allows the state to go back, or the plan to
2 recover services that are Paid Pending. We saw that
3 changed. And I don't know if I read that correctly but
4 that might be -- it's a good thing for beneficiaries.
5 Obviously, it's not a thing that I think, from a
6 beneficiary protection position, is very good, for people
7 to have to worry about having their benefits clawed back,
8 if it turns out when they get through the process that it
9 goes against them.
10 And so I would just double-check to make sure
11 that I've read it the right way, because it's very
12 confusing. That whole unified appeal section was a little
13 hard to get through. It was very dense.
14 And I think that was it. And again, I think
15 we're glad that it's still -- the state is the one that
16 still decides sort of the scope of the arrangement that
17 they have. I think we think that MMCO did a very gentle
18 approach to this and deferred a lot to the states. You
19 know, our fee-for-service states are really struggling with
20 how to manage integration when they don't, either can't or
21 won't, for policy reasons, capitate services.
22 And so they're trying -- I think some of them

1 would actually like to go beyond, which is funny, not only
2 that you said you're hearing some grumble from the states.
3 Our fee-for-service states actually would like to have -- I
4 think have started to use their MIPPA contracts more
5 broadly to drive some integration with their fee-for-
6 service LTSS program. Not all, but I think a number of
7 them are looking for better ways to get hold of the duals.
8 It's all we talk about now at our meetings is, you know,
9 how to get control of the duals when you can't deal with
10 Medicare.
11 That's it. Thank you.
12 COMMISSIONER BURWELL: So I guess I have a
13 question. So if you're a D-SNP in a fee-for-service state
14 that doesn't do MLTSS, the only way to meet this
15 requirement is the first option. Is that correct?
16 MS. VARDAMAN: Yes.
17 COMMISSIONER BURWELL: Yes. I'm also trying to
18 think through. I mean, states do switch their MLTSS
19 contractors sometimes, which will affect the aligned D-SNP,
20 but I guess if you lose it on the Medicaid side you lose
21 the D-SNP too.
22 COMMISSIONER BELLA: They released policy about a

1 year ago that allows, for a time, when the plan change
2 happened there's an enrollment mechanism to allow to change
3 that member into the new plan so that they still have that
4 alignment. It happened in Arizona. So they do have --
5 they are looking toward having a mechanism to pull the
6 beneficiary with that for continuity. So it's not perfect.
7 And the grumbling, Camille, I totally agree with
8 you. The grumbling was about do I have the systems and the
9 IT in place to do the reporting.
10 MS. DOTSON: Yeah.
11 COMMISSIONER BELLA: It wasn't absolutely they
12 want more tools. I totally agree.
13 MS. DOTSON: Yeah. To me that's a problem.
14 COMMISSIONER BELLA: Yeah.
15 MS. BLOM: Can I ask one question? Commissioner
16 Bella, you mentioned that the intent was to have more
17 states take up the -- or do what FIDA did, basically. Do
18 you have a sense of why that hasn't occurred? I mean, Part
19 D was kept outside of New York's process anyway, right, so
20 --
21 COMMISSIONER BELLA: [Speaking off microphone.]
22 MS. BLOM: It was brought in? Okay.

1 COMMISSIONER BELLA: I believe it was brought in
2 while I was still there. I can double-check that. And my
3 guess is it just fell so lower on the priority list. That
4 the thing was -- the thought was, at that time, to learn
5 from New York and then see if we wanted to expand that to
6 the other demonstration states, and perhaps just other
7 things have taken priority. I don't know.
8 VICE CHAIR LAMPKIN: Any other comments or
9 questions?
10 [No response.]
11 VICE CHAIR LAMPKIN: All right. It's a wrap.
12 CHAIR THOMPSON: Great. Terrific day, as always,
13 Commissioners. Thank you to the public for your
14 contribution. We will see you tomorrow.
15 * [Whereupon, at 4:12 p.m., the meeting was
16 recessed, to reconvene at 9:00 a.m. on Friday, December 14,
17 2018.]
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19
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21

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

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1 P R O C E E D I N G S

2 [9:02 a.m.]

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

5 [Pause.]

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

10 I think, as everybody knows, we've been having
11 these conversations around the Puerto Rico situation. We
12 have issued some issue briefs associated with that. We
13 have a request for some data and some information in the FY
14 2019 Labor, Health and Human Services, and Education
15 funding bill that we want to respond to. This conversation
16 this morning will help us move along towards meeting that
17 request.

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

22 Kacey, you're going to kick us off here this

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

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

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

12 At our last meeting, I provided an overview of
13 how the program works and pointed to some of the challenges
14 the program and the larger health care system are facing,
15 which include ongoing hurricane recovery efforts, access
16 and infrastructure challenges, as well as a capped Medicaid
17 allotment and the upcoming expiration of supplemental
18 federal Medicaid funding, sometimes referred to as the
19 "Medicaid fiscal cliff," coming up as soon as September
20 2019.

21 Additionally, Puerto Rico's Medicaid program is
22 subject to spending reduction targets required over the

1 next five years by the Financial Oversight and Management
2 Board for Puerto Rico and is currently undergoing some
3 reforms to help achieve those targets.
4 So to help provide the Commission with a deeper
5 and more nuanced understanding of these issues, we have
6 convened an expert panel who can offer their insight on the
7 situation on the ground, the reforms and opportunities and
8 challenges in the near and longer term.
9 And so the panelists are Angela Avila, executive
10 director of the Puerto Rico Health Insurance
11 Administration, or ASES, which is the agency in Puerto Rico
12 responsible for many things, including overseeing and
13 contracting with Medicaid managed care organizations. And
14 Ms. Avila has been with ASES since 1997, working in diverse
15 areas, including finance, statistical analysis, contract
16 negotiation, and ICD-10 implementation. And she has
17 occupied positions ranging from finance director, analyst
18 administrator, and executive subdirector, so she has
19 intricate knowledge of the Medicaid program.
20 We also have Orlando Gonzalez, president of MMM,
21 a Medicaid managed care company operating in Puerto Rico.
22 He has been president of MMM since 2008, and his

1 professional trajectory includes positions such as
2 administrator of the Puerto Rico Socioeconomic Development
3 Administration and executive director of ASES.
4 And then, lastly, we have Gloria Amador, CEO of
5 Salud Integral en la Montaña, which is a federally
6 qualified health center offering primary and preventive
7 health services throughout its network of community health
8 center locations in several different municipalities. Ms.
9 Amador has over 20 years of administrative and leadership
10 experience in the health sector, including 11 years as the
11 auxiliary director of Special Programs for the San Juan
12 Department of Health, where she supervised 18 local, state,
13 and federally funded programs. And she's also held a
14 number of different board and committee memberships.
15 And so to get us started, I will turn it over to
16 Angela who can discuss ASES's view.
17 * MRS. AVILA: Well, good morning, everybody. For
18 me, it's an honor to be here and have the opportunity to
19 share some information about Puerto Rico and our government
20 health system in the island. It is really just like a
21 dream come true to be able to show what we are confronting
22 in Puerto Rico in terms of the needs in our health care

1 system.

2 I have been working, as Kacey mentioned, for more
3 than 20 years in the government of Puerto Rico and
4 specifically in the Puerto Rico Health Insurance
5 Administration, so I have had the opportunity to see how
6 the managed care system has been developed in the island.
7 So this has been a 20-year experience of dealing with
8 managed care for more than 1.3 million participants in the
9 Medicaid program.

10 So it is a great opportunity to share with you
11 what we are confronting right now, and as in the invite,
12 they asked me to address some specific topics, and that's
13 what I'm going to try to do in just like ten minutes, eight
14 to ten minutes.

15 So I would like to start just saying that Puerto
16 Rico has a 100-percent managed care model for the Medicaid
17 program, and as I mentioned, we have 1.3 million, almost
18 1.3 million participants in that program. It is managed
19 care. We used to have a regionalized system, and that
20 means that we used to have presence of managed care
21 organizations in eight different regions. It was one
22 managed care per region, and right now, we are doing some

1 major changes in terms of improving the health system,
2 improving the managed care, improving the competence, and
3 just going to go for quality outcomes. We want to pay for
4 quality outcomes instead of paying for a per member per
5 month premium without any other considerations.

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

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

22 Nevertheless, we can do a lot of changes in the

1 managed care area, but our biggest challenge right now is
2 the sustainability of the system. And we have been
3 confronting an underfunded system for more than 20 years in
4 Puerto Rico, and no matter which changes we can include or
5 implement, if we don't have the right funding, we would not
6 accomplish that sustainability and continuity of the
7 program.
8 We are confronting in the near period right now,
9 short term -- we are confronting challenges. We don't have
10 providers that are willing to accept any other reductions
11 in their rates. Our providers -- a doctor in Puerto Rico
12 earns less than a hair stylist. A doctor for a visit gets
13 like $10, and when you go and do your hair, you spend more
14 than $50. And that's the disparity we are confronting.
15 When we compare what the Medicaid programs
16 throughout the states and other territories are receiving
17 for the program, it is a difference between $400, $500 per
18 member per month to almost $200 is what we have per member
19 per month to cover the entire system right now. So it is
20 so difficult to have doctors that have been educated in a
21 way that meets the state standards -- we have our good
22 doctors that go through all the boards in the States, and

1 they know how to speak both languages. And we don't have
2 resources to keep them in the island.
3 So, lately, since before the hurricanes, we're
4 starting to see an exodus of the professionals in the
5 island and mainly in the clinical areas, and our health
6 professionals are leaving the island. So it is very
7 difficult, even though if we have some grants to cope with
8 the needs of paying some reasonable amounts to these
9 professionals to be able to keep them in the island.
10 Also, one of the other biggest challenges that we
11 have is the beneficiaries, people that find other -- with
12 medical needs in the islands are also leaving and getting
13 to the States to find those services and have better
14 quality of services there.
15 So we have a mixture of some, two very important
16 causes that we need to keep on tracking and see how can we
17 look for mechanisms and collaborations and better funding
18 for our health program in Puerto Rico.
19 And the main one that we are confronting in a
20 short term is the cliff, the famous Medicaid cliff in
21 Puerto Rico. We were experiencing this cliff before the
22 hurricanes in 2017 because of the ACA funds, the period of

1 ACA funds for Puerto Rico. So right now, we have the
2 release of the BBA. We are counting for first time
3 historically 100 percent parity in Puerto Rico for the
4 Medicaid program.
5 It took two hurricanes and an emergency of huge
6 impact in the island to be able to receive 100 percent
7 parity in the Medicaid program, and it has been almost a
8 miracle, I will say, because that way we could do the
9 implementation of the new model. We comply with the
10 requirement of the fiscal board because if we don't have
11 any warranties, we cannot proceed with any negotiations if
12 the fiscal board doesn't approve it. So if we don't have
13 the appropriations certified from the Congress and HHS, we
14 cannot do anything in the island in terms of new
15 negotiations and implementation of anything related to the
16 health care.
17 So thanks to the BBA, we have been able to
18 accomplish a new model, a new negotiation. Right now, we
19 have five main companies that are willing and doing the
20 management of our Medicaid program in terms of services,
21 and what happened is that that effort is only for 18 months
22 and is going to end in September 2019. So it's going to be

1 -- again, we need to face another cliff, another situation
2 uncertainty. We don't have a recovery funding that would
3 meet our actual expenditure in the island.
4 And just to give you an idea of how the disparity
5 is, when we compare with other states, we are like in
6 position 12 of the states that have -- states or
7 territories that have the most population under the
8 Medicaid program, and we are receiving funding in
9 comparison with the 48th state or territory that receives
10 the lowest amount of funding for their programs. That's
11 the type of disparity that we are talking about.
12 So my message, we have a lot of information. We
13 have the projections. We have all the details that you may
14 need, and anything else that you may ask, we are more than
15 willing to share with you and have the opportunity to bring
16 the message.
17 I brought here expertise that like Milliman are
18 our actuaries in Puerto Rico, like Mercer are our
19 consultant for pharma affairs. We have all the things
20 here. If you have any questions, any doubts, we are more
21 than pleased to answer whatever information you may need to
22 help us just do a better job and send a message for Puerto

1 Rico.

2 We want in Puerto Rico to stay there. We love

3 our island, and we would like our people to go because they

4 want to, not because they need to. There is a lot of

5 potential in the island. We have a great economy and an

6 opportunity of economy. We have like -- we used to be like

7 4 million Puerto Ricans. Right now, we are almost 3.4, and

8 people are leaving. And we need urgently to look for

9 permanent solutions to avoid that, look for permanent

10 solutions to Puerto Rico being an asset for the States.

11 We are very proud of being American citizens.

12 That's for sure, and that's why I'm here, just for that.

13 So thank you so much for the opportunity.

14 * MR. GONZALEZ: Good morning. My name is Orlando

15 Gonzalez. I am the president of MMM, as Kacey has said. I

16 have been 12 years with the company on the insurance side,

17 but before that, I was the executive director of the

18 largest hospital in Puerto Rico, Auxilio Mutuo. Before

19 that, I used to occupy the chair that Angie holds today, so

20 I used to be the executive director of ASES. So that means

21 that even though I'm representing an insurance company, in

22 reality, probably my perspective would be a little bit

1 broader than that because I have been able -- I have the
2 opportunity to be in multiple sides of the industry.
3 And I put together a couple of slides just to
4 make reference to, hopefully be brief, so you guys can
5 really spend the time making the questions. But, as Angie
6 said, this is a managed care, 100 percent managed care for
7 more than 20 years on the island, $2.7 billion that is
8 invested every year to provide access to cover covering 1.3
9 million people with over 6,000 unique providers. It is a
10 block program versus an entitlement, and that's very
11 important. There's going to be some data that I'm going to
12 be sharing with you as to the challenges with that.
13 Interestingly, through the program, more than 50
14 million prescriptions are provided every year, investing
15 more than $600 million there.
16 There's a particular item. That's why I want to
17 highlight this because you will see later on the impact
18 that the prescription drugs has on the overall program, and
19 then it creates about 16,000 or so employees, employment on
20 the island, so it's a very huge program.
21 As Ms. Avila said, 47 percent of the Puerto Rico
22 population participates in Medicaid. That's unprecedented.

1 No other jurisdiction of the state has such a high level of
2 participation, so that's particularly the importance of the
3 program, but it also speaks as to the socioeconomics of the
4 island, which is the main issue. I mean, we have people --
5 if you see there a profile of the participants within the
6 program, 50 percent of them make less than $10,000 a year.
7 Seventy-one percent of them are unemployed. Seventy-six
8 percent of them are below federal poverty level. Sixty-six
9 percent of them have lower than a high school diploma.
10 Fifty-four percent of them are single, claim to be single,
11 and 71 percent of them also get nutrition assistance
12 program. So, as you can see, it's a very poor and
13 uneducated population.
14 You see the data on reimbursement. This is, I
15 believe, the key of the issue. Look at the reimbursements
16 per member per year that are invested on Medicaid, the
17 spending that is invested in Medicaid in each of the
18 states, and then you see the right side, a green bar and a
19 red bar. Those are Puerto Rico. The green one, it's
20 what's currently being invested in the program.
21 Right now, it's at 100 percent FMAP because of
22 the temporary funding that was assigned at the beginning of

1 last year after the hurricane. If we were to turn that to
2 what is mandated by law, the 55 percent FMAP, that number
3 would go down to basically $1,100. It doesn't matter how
4 you look at it. Actually, even with 100 percent FMAP and
5 with the additional funding that Puerto Rico is getting,
6 it's 50 percent of the lowest state. So you're having the
7 highest penetration, probably the poor people in the whole
8 country, getting half of the lowest state to get services.
9 What is the issue with that? Of course, there's
10 going to be multiple challenges when you have that
11 situation because when you go and see the health
12 conditions, Puerto Rico is not healthier than other people
13 in the states. Actually, it's sicker. If you'll see, for
14 example, diabetes, you'll see the green line. Puerto Rico
15 scored highest than any other country in terms of
16 prevalence of diabetes, but we have the less funds. You
17 see the blue bar. So we have highest condition, less
18 funding.
19 If you move to look at the right side and you see
20 the cardiovascular diseases, again, scoring very high, very
21 low funding.
22 If you move to the next one and you see

1 hypertension, similar situation. We're among the top on
2 prevalence, lower funding.
3 The same is true for high cholesterol.
4 So you see we have a population that is very sick
5 with a lot of chronic conditions, but we have less funding.
6 You can argue there is a correlation that they have
7 developed those conditions because of the historical lack
8 of funding that Puerto Rico has received. Nevertheless, if
9 we don't get the funding, this is not going to get better.
10 It's going to get worse, and that's concerning. And not
11 only that, it's concerning for the program as a whole
12 because you will see later on what are the impacts and the
13 effects of this disparity.
14 Moving into the next one and trying to sort of
15 put some data as to what are the issues that create this
16 lack of disparity, let's take pharmacy as an example.
17 Pharmacy, it's the pricing of the pharmacy that the
18 insurance company has to pay. The pharmacies and the PBMs
19 are based on AWP, similar to the States, and actually, the
20 pharma companies cannot lower the price because if they
21 lower the price, they have to honor that price to the other
22 states. So what they do is they keep the price consistent

1 with the state.

2 But if you saw that we have 50 percent less
3 funding than in the States, but you got to pay the same
4 price on drugs, what happens? What happens is that the
5 other providers are going to get much, much less dollars
6 because the premium is fixed. It's a block. It's a block
7 program. So what happens is that it puts undue pressure on
8 other providers, and you'll see doctors getting much, much
9 less dollars, and you'll see hospitals getting much, much
10 less dollars because it's the only way that the system can
11 operate under those circumstances.

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

21 What is the impact of that? That put pressure,
22 and then doctors and other sectors are getting less

1 dollars. In our case, that second bullet is MMM data
2 specifically. That impact alone represented more than $5
3 million less going into the pockets of the doctors. If you
4 extrapolate that to the program, we're talking about over
5 $20 million, just one year over $20 million less going to
6 the doctors, into the doctors' pockets.
7 What happened then? When you see the
8 compensation of physicians and providers and other health
9 care professionals in Puerto Rico versus the States, we are
10 in a very disadvantaged position. Let me tell you, --
11 there's these people that -- many of these doctors train in
12 the States. They train in the States, or they train in
13 segregated organizations in Puerto Rico, and they get, in
14 some instances, 50 percent of what other professionals get.
15 What happens is that Puerto Rico's -- because
16 Florida, Texas, New York, other jurisdictions are going to
17 the island to hire doctors, offering twice the salary to
18 get them out of the island, creating a crisis, a crisis for
19 us, and actually putting Puerto Rico in a much
20 disadvantaged position.
21 You see that chart in the middle, it's estimated
22 that in the last five years, we have lost more than 1,100

1 doctors, and if you see that chart -- I'm sorry for this
2 slide. It's a little bit crowded, but I thought it was
3 important to put this data point. But if you see that
4 chart with the blue and the green bars, look at the mix in
5 terms of age of the Puerto Rico physicians. Look at the
6 young doctors, 35 years or younger, Puerto Rico has 4
7 percent versus the States with 24. And as you move to the
8 right, we have a more concentration of older doctors, so
9 that basically confirms young doctors are leaving the
10 island. Older doctors are staying because they already
11 have their practices for 20, 25 years. It's hard for them
12 to close those practices and leave, but this is going to be
13 an issue for the island in the upcoming years because as
14 these guys start retiring, Puerto Rico is going to lack
15 doctors to take care of the patients, unless something is
16 done to fix this issue and we can start providing a better
17 compensation to our doctors.
18 And this is not just impacting the doctors. Look
19 at what happened to the members. This is data from 2016
20 that shows that out of the people that Puerto Rico has
21 lost, a large number of the people is Medicaid people.
22 Most of them go to Florida, and this is the most bizarre

1 situation because they go to Florida, and then the federal
2 and the state government ends up paying three times what
3 they pay in Puerto Rico.
4 So by increasing a little bit of Puerto Rico and
5 creating stability in Puerto Rico, you will save as a
6 program, as an overall, significant amount of dollars
7 because every member that goes to Florida, it is costing
8 the system three times more than what it costs to keep them
9 and treat them in Puerto Rico.
10 So Ms. Avila said it very clear. The uncertainty
11 really is -- it's really destroying the system.
12 Right now we're facing that in the -- next click
13 -- in the third quarter of '19. Actually, negotiations
14 with the insurance companies will take place on Q3 of '19.
15 So the issue and the situation for us, as insurance
16 companies, is we're going to be negotiating something
17 without the certainty of what's going to happen, whether
18 the funds are going to be available or not.
19 And that creates a lot of impact, also, on the
20 program as a whole but on providers, and, you know, it's
21 going to continue to contribute to the shortage that we
22 have in certain specialties. We have a shortage of

1 endocrinologists, rheumatologists, neurologists,
2 psychiatrists. And particularly psychiatrists, I want to
3 emphasize that one because one of the main issues that
4 we're facing after the hurricane is a significant increase
5 of suicides and a significant increase of depression and
6 anxiety. The statistics show that suicides have gone up
7 more than 18 percent on the annum.
8 So it's a fragile infrastructure after the
9 hurricane. You know the island was very, very a long
10 period of time without power. Hospitals were severely
11 impacted. There are some hospitals that are operating
12 maybe at 20 percent of what they used to operate. Of
13 course, they're in the process of, you know,
14 reconstructing.
15 Take, for example, the island of Vieques, which
16 is a municipality. It's an island on the east part of
17 Puerto Rico. It's still running on generators, and for
18 dialysis those patients were being brought to the island
19 three times per week until about a month ago, that
20 temporary facility was set up so that they can take the
21 dialysis, you know, at the municipality.
22 The doctors were very impacted as a result of the

1 hurricane because they didn't have the infrastructure to
2 deal with this, so that put a lot of pressure on the
3 hospitals, as the doctors were not available to take care
4 of the patients on an ambulatory level.
5 As I said, the concerns regarding the mental
6 health and the depression and anxiety, and, you know, there
7 is some statistics that, you know, shows that at least
8 almost 3,000 people, you know, died as a result of, you
9 know, not getting the treatment, the care that they needed
10 after the hurricane.
11 So to conclude, recommendations, I think it's
12 important for Congress to act and to put reasonable
13 financing. I don't think anybody here will be asking for
14 treatment similar to any states. I don't think that's the
15 proposition. I think a reasonable cap pretty much
16 consistent with what we're getting after the emergency.
17 And, you know, my recommendation will be, or our
18 recommendation will be to keep the 100 percent FMAP at
19 least for two more years, until the island recovers, and
20 then have an FMAP equivalent to 83 percent, which is sort
21 of what Puerto Rico will be getting if we were treated with
22 parity.

1 Remember, the situation with the block is
2 twofold. One is amount. The second one is FMAP. So if we
3 get a reasonable amount and a reasonable FMAP. Even with
4 that, Puerto Rico will still be 50 percent lower than the
5 lowest state. I'm not asking for same amount of any other
6 state. I'm saying even with that, Puerto Rico still will
7 be in a disadvantaged position, but at least with more
8 certainty to invest on the program to put more dollars to
9 providers.
10 I think important is also to promote quality. If
11 you look into the Medicare side there is a five-star
12 program that is very robust to promote quality, and the
13 plans have done a good job in Puerto Rico. Actually, the
14 three largest players in Puerto Rico are four-and-a-half
15 stars, with 95 percent of the people in Medicare Advantage
16 in Puerto Rico are covered by four-and-a-half-star plans.
17 So I think Puerto Rico takes these topics very seriously.
18 So I think something similar, special funding for
19 that will be interesting and something that can be defined
20 between the states and the Federal Government as part of
21 the state plan. And also, if you look at the Medicaid
22 side, certain services are not provided on the island. We

1 don't have the providers because there is no funding, no
2 infrastructure. So perhaps demonstration projects, I mean,
3 funding for demonstration projects can be also put in place
4 to promote things like PACE, for example, that are precise
5 to address fewer people with community base in coordinate
6 with Medicaid and Medicare. So those are, you know, just
7 to name an example of things that can be done.
8 So thank you very much and I am open later on for
9 any questions.
10 * MS. AMADOR: Good morning, everybody. Thank you
11 for the invitation to be part of this panel of the MACPAC.
12 The previous panelists have presented and I also had the
13 opportunity to be on the government and the private
14 hospital industry in Puerto Rico. So today I'm presenting,
15 as a CEO of one of the biggest FQHCs in the central region
16 of Puerto Rico. You have the presentation as referenced.
17 The first slide is only a profile of our
18 organization. We have nine sites, four emergency rooms,
19 and two mobile units located in seven municipalities. We
20 also run home care and hospice certified Medicaid programs.
21 We have over 540 employees. Last year we reported to the
22 Federal Government 39,002 patients that we served. Our

1 budget, federal funding is around $16 million, and we run
2 an operation of over $75 million. It's just one small
3 cluster of the providers but you can see how big is our
4 impact in the central region of Puerto Rico, with just a
5 lot of shortage of doctors and services in that area.
6 Seventy-eight percent of our population is Medicaid
7 patients, so we depend on the managed care system to
8 provide services to this population.

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

18 And also the population we serve are the more
19 vulnerable populations, including the underserved, the
20 economically distressed populations, the uninsured, the
21 migrant seasonal farm workers, individuals and families
22 experiencing homelessness, and those living in public

1 housing projects, as well as HIV/AIDS patients who are very
2 costly to treat.
3 This is just a reference from Medicaid in Puerto
4 Rico. We started managed care models in 1993, and that's
5 the way we have been providing services, health services,
6 through the distinct managed care organizations, through
7 risk-based contracts. The government contracts with the
8 MCOs and they contract with the providers, with the IPAs or
9 the FQHCs, through a fee per member per month capitated
10 payment, so we can provide all the services to the
11 population.
12 We also receive a supplemental wraparound payment
13 from the commonwealth that is to cover the difference among
14 our costs, our service costs, and to what we receive as
15 capitated payment.
16 The State Children's Health Insurance Program,
17 you also know all about the law that covers that, but
18 specifically in Puerto Rico the CHIP funding is based on
19 the number of low-income children receiving it in each
20 state, but in Puerto Rico it's burdened by two
21 discriminatory caps. One is the funding allotment not
22 based on the number of children and also that the federal

1 matching rate limited to territorial cap of 55 percent
2 instead of the maximum of 83 percent if we were treated as
3 a real state.
4 Also, the FQHCs are required to provide care to
5 those CHIP beneficiaries as if they were located in any of
6 the 50 states, although the unequal reimbursement rates
7 that we receive.
8 This is the statistics of the 20 FQHC
9 organizations in Puerto Rico. We report, in the UDS --
10 that's a uniform statistic report that we submit to HRSA,
11 to the federal health department. We serve 240,000
12 patients, representing 20 percent of all the Medicaid
13 patients in Puerto Rico. There’s over 32 -- in our
14 organization, 32,500 Medicaid patients in my organization
15 alone, and the patients on Medicaid that we expect next
16 year is 1.2 million patients in Puerto Rico. So 2 out of
17 10 patients in Medicaid are receiving services at any of
18 our FQHCs in Puerto Rico. So you can have the perspective
19 of how important is our settings in Puerto Rico.
20 Also, part of the unequal treatment in the
21 funding to Puerto Rico was the funding for the Medicare
22 program. It's subject to territory cap. We have the FMAP

1 in a minimum of 50 to 83, but we are set in 55 percent. So
2 if we will receive the 83 that we are supposed to be
3 receiving, due to the poverty levels that Puerto Rico, the
4 island have, so we will be receiving that sum of the 83
5 percent, representing billions of dollars additionally to
6 Puerto Rico.

7 What about ACA? Angie talked a little earlier.
8 ACA made three principal changes to the federal
9 contribution to Puerto Rico Medicaid program that
10 permanently raised the FMAP to 55 percent, provided $5.4
11 billion, above the statutory cap to cover July 1st, 2011 to
12 September 2019, and also for the subsidies for the
13 Marketplace coverage, Puerto Rico receive additional $925
14 million. But the unfair treatment to Medicaid with
15 temporary funding is still capped, and the FMAP is
16 significantly below the 83 percent that it would be if its
17 rate was based on a non-capped formula.

18 Puerto Rico would have fallen into a cliff, but
19 Hurricane Maria make a difference on the funding we
20 received last year. As Angie also told, Maria -- and
21 Orlando told you a little bit about what happened with
22 Maria. Maria was the deadliest hurricane to hit the United

1 States in the last 100 years. We were without energy,
2 without water, without diesel, without ATMs, without banks,
3 without port, without airports, so everything was shut, and
4 especially the infrastructure on the health system was
5 demolished. Many of the hospitals were closed. Less than
6 15 percent of the hospitals were running on the first week
7 of the hurricane, after the hurricane. And the federally
8 qualified health centers were the only ones responding in
9 the communities to provide services to the patients. So we
10 were an ally to the government to provide services in the
11 most difficult times in the island.

12 Thanks to the Congress we received funding, in
13 the Bipartisan Budget Act in 2018, that is until September
14 30, 2019, and that's where the most concern is. What's
15 going to happen when we get to September 30, 2019?

16 Also, in Puerto Rico there is restrictions on the
17 eligibility requirements due to the cap on the funding,
18 that Puerto Rico has to establish a Local Poverty Level.
19 So a lot of patients are getting out of the managed care
20 system, so it represents that those patients now are being
21 converted to uninsured and most of those patients are
22 coming to our health centers to receive the services

1 because nobody else is giving them the services if they
2 cannot pay.
3 So the use of the Local Poverty Level instead of
4 the Federal Poverty Level results in lower Medicaid
5 enrollment that directly affects the FQHCs in fewer
6 Medicare patients assigned, which decreases our capitation
7 and our wraparound revenues, meaning more uninsured
8 patients.
9 So what's going to happen after September 30? So
10 Puerto Rico fully expects that after that we will revert to
11 the statutory cap of $357 million. The possible
12 consequences once Puerto Rico reaches the new Medicaid
13 cliff is that the commonwealth probably will no longer be
14 able to comply with the wraparound payment to FQHCs. The
15 Medicaid enrollment will decrease in beneficiaries,
16 equivalently reducing FQHC's assigned Medicaid populations
17 and capitation, as I already said, and will translate in
18 decreasing revenue and in excess of millions of dollars a
19 year.
20 FQHCs will be forced to treat a proportional
21 increase of uninsured patients without corresponding state
22 reimbursement. So even if we receive wraparounds and we

1 receive capitation and we receive federal funding, we won't
2 be able to subsidize those uninsured patients because money
3 have a certain -- designated to certain operational costs
4 and to services, so we probably won't have the capacity to
5 serve all the population.
6 So some of the barriers that Hurricane Maria and
7 the unequal treatment, and with this I'm closing my
8 presentation. Patients suffer significant challenges in
9 accessing physician specialties and difficulties in
10 receiving referrals. During the hurricane, a lot of
11 medical offices were shut down, so it was very difficult
12 for them to continue with their treatment and to get their
13 medications. So a lot of patients were coming to the
14 health centers, to the federally qualified health center to
15 continue their treatment, even if they were patients that
16 belonged to other providers in the area.
17 Many Medicaid offices are closed, causing that
18 patients cannot recertify on time, and currently the
19 recertification appointments are for February of 2019,
20 after the enrollment period, which caused a delay for
21 beneficiaries to remain active in the program. Now there
22 was a waiver that allowed patients for a whole year to come

1 to continue their enrollment in the Medicaid program, but
2 now that they are coming back to recertification there's so
3 many people getting into the process that the appointments
4 are for next year. So it's going to be very difficult for
5 them to get services between November and January this
6 year, because they won't be able to recertify.
7 Also, there is new requirements and established
8 criteria disqualifying many beneficiaries, such as those of
9 the CHIP programs where the mother of a child, if left
10 without the coverage, due to new restrictions requirements,
11 although FQHC accept them and assume the economic burden,
12 but if the mother is out of the system the child is going
13 to be out of the system too.
14 The Puerto Rico Health System has become one
15 subsidized by the federally qualified health centers, due
16 to all the population have been left without the health
17 coverage, and the FQHCs have continued to offer those
18 health services to them.
19 Another barrier is that Hurricane Maria caused
20 great damage to the system and caused, for several months,
21 a barrier to access to health care services on the island.
22 Drug donations resulted in savings for insurers who did not

1 pay for the services provided through the waivers offered,
2 rejecting claims. And today we are still working with
3 insurance companies to get paid for all the services we
4 provide to patients who do not belong to our organization.
5 The cap on Medicaid program drives us to a gap in
6 funds, and also a gap in care. The New Single Region Model
7 established by the health government has increased the
8 costs of managing the program because the five insurers do
9 not operate the same way. So now the federally qualified
10 health centers or the providers need to have additional
11 operating staff to cover all the regulations that these new
12 five contracts give us to maintain the compliance with all
13 of them.
14 FQHCs are required by federal law to provide its
15 medical services to all patients, regardless of their
16 ability to pay. An unexpected increase of uninsured
17 patients in Puerto Rico will translate in more patients
18 into our system, and we don't have the total federal
19 funding to cover them.
20 And the consequences of this unequal treatment is
21 that we will face a Medicaid funding crisis, leaving more
22 than a million U.S. citizens without coverage. The

1 significance of inadequate funding are rolled along the
2 weakest link of the chain, that is the providers and the
3 patients. The Commonwealth of Puerto Rico is burdened with
4 a second-rate health system, and also unequal treatment
5 directly targets the most vulnerable populations in Puerto
6 Rico: the elders, the poorer, and the unprivileged
7 children.
8
9 And the recommendations is that there should be a
10 change in the formula used when allocating the funds in the
11 health area that allow citizens to access better services
12 that result in better quality of life. Only with the
13 Congress' intervention, Puerto Rico will have the necessary
14 funds for its Medicaid and CHIP programs to continue
15 operating after October 1st, 2019. Allow services not
16 currently being provided, such as long-term care, and also
17 give flexibility to use funding for programs that heed
18 social determinants of health. That's a very important and
19 significant area that we have to treat.
20 And to finish, follow up implementation on the
21 Health Innovation Plan that was created in consensus with
22 all the stakeholders and approved by CMS to create a bridge

1 of the current situation to value-based models. I have the
2 document here. I can leave it as a reference if you don't
3 have it. But there is a lot of information that was
4 gathered through a lot of stakeholders to look for new ways
5 to implement innovative models to decrease the cost of
6 services and to increase the quality of services.
7 Thank you very much.
8 CHAIR THOMPSON: Thank you all. First of all,
9 that was very informative, and as you were going through a
10 number of your slides and remarks, I think it really
11 responded to some earlier conversation that we had in this
12 Commission about things that we were interested in learning
13 more about, so you've really put us on the road to
14 understanding the situation much better.
15 I want to open it up to the Commissioners. We'll
16 have about 25 minutes' worth of time here to ask some
17 questions of our panelists. So let me start off with
18 Sheldon and then go to Martha, then Peter.
19 COMMISSIONER RETCHIN: Well, first of all, thank
20 you for your participation in the panel discussion. For
21 me, it continues to be a heart-wrenching situation, and
22 here's where I'm at, and maybe you could help me out. We

1 could talk about it as well from others, maybe Kacey could
2 provide -- the gap. So if the cap was changed to 83
3 percent of an FMAP, how big is that number? And then in
4 your view, if -- I mean, one of the things that is
5 bothering me about the whole discussion isn't that a
6 decision might be made to change the FMAP and lift the cap
7 for funding Medicaid. I'm assuming that in traditional
8 congressional action it may happen in August of 2019.
9 In the meantime, the uncertainty appears to be
10 draining both the medical workforce -- and I guess my
11 question -- to get back to my question -- is whether you
12 think changing the FMAP sooner than later will prevent the
13 out-migration of citizens of the island, and particularly
14 into Florida. It's a complicated question, but, I mean,
15 without -- what do you think a sooner action than later
16 would really do?
17 MRS. AVILA: Excellent question. We were just
18 figuring that number, the specific number that would be if
19 we approach the 83 percent. We were talking -- and if I'm
20 mistaken, José, please verify. We were talking about $600
21 million per year in differences in funding. And if
22 we...get to that point -- I'm sorry. Sometimes we are

1 looking for the specific words. What we are going to allow
2 for is just to be able to bring better fee schedules for
3 our health care professionals, and only that movement and
4 that initiative will bring a lot of growing concern for the
5 health system. So for us we need to identify additional
6 funding to pay better doctors and health professionals.
7 And in order to establish those fee schedules as guidelines
8 our positions, we will need the additional funding. Right
9 now, with the BBA, the $4.8 million, we were able to keep
10 what we have up to October 31st. We asked the managed care
11 organizations not to reduce any penny to the doctors and
12 professionals, and that was the agreement. If we keep this
13 budget, we can at least stop decreasing fee schedules
14 because that was imposed by the fiscal board, and we can
15 keep the system until the health care -- the federal health
16 care system can give us some guidelines and us to be able
17 to insert that in those new exchanges.
18 On the other hand, when I started coming to the
19 Congress and see what was happening, everybody told me you
20 can keep on going with 100 percent managed care models, but
21 everybody has found out they are very costly, and we need
22 to look for other alternatives. And that's why we got into

1 the new system because we were looking for some immediate
2 cost containment initiative, and that's why in the middle
3 of the hurricane and just after the hurricane, we started
4 working with the new model because we cannot have the
5 luxury of having the BBA and do nothing, because it's not
6 going to change. So that's why we open for competence. We
7 are dealing with high-cost, high-need populations to be
8 able to treat the specific condition and the patient and a
9 fixed premium amount that will take care of whatever is
10 available, or you can do with that money. So we have put
11 some short-term initiative that will stable the cost
12 increase in terms of the model, and that's the way that we
13 have been working so far.
14 So the answer is yes, the money will allow us to
15 have at least a stable system until doctors and
16 professionals see that we are doing something that is bring
17 some hopes and opportunities to remain in the island.
18 MR. GONZALEZ: If I may add, there is no doubt
19 that, you know, time is of the essence. I think it's sort
20 of where you're heading. The sooner the better. We
21 understand there are processes. I mean, this is probably
22 things that can't happen overnight, but there is no doubt

1 that the sooner the better. The island is definitely in
2 need of positive news. It is being bombarded by, you know,
3 the debt crisis, then the hurricane, the system, you know,
4 the next cliff. And when you have such an environment and
5 then you have companies that are targeting the island
6 because you get professionals, bilinguals, some of them
7 even train in the states, used to work under very rough
8 circumstances, and when they go to the states and they have
9 to work with these new very fancy facilities, servicing,
10 very organized, you know, they're stars because they're
11 used to working with very tough situations.
12 So it's very attractive, and companies and
13 hospitals and health care organizations in the states have
14 realized that, and every month we have a couple of fairs of
15 different companies going to the island looking for nurses,
16 looking for pharmacists, looking for physicians, because
17 they have identified, you know, low-hanging fruit of people
18 that are willing to listen because of the uncertainty that
19 they are living every day.
20 CHAIR THOMPSON: So I have Martha, Peter, Kisha,
21 Stacey.
22 COMMISSIONER CARTER: Thank you for your

1 presentation. I wanted to highlight an issue that I heard
2 and a question. So the FQHCs take care of 1.2 million
3 Puerto Ricans, which is 20 percent of your Medicaid
4 population. So I'm trying to wrap my head around, you
5 know, you have a mandated rate, a PPS rate, which the state
6 must pay or the commonwealth must pay, and without that
7 funding, what's going to happen? You know, the FQHCs can't
8 survive, obviously. So, I mean, it really puts that whole
9 health center system, the community health center system in
10 grave jeopardy, and puts the state in a Catch-22 of
11 noncompliance. You're not getting the money, but you're
12 mandated to pay it. Correct?
13 MS. AMADOR: Yeah. Let me clarify. The 1.2
14 million people are the beneficiaries of Medicaid -- the
15 federally qualified health centers serve only 20 percent of
16 them. Last year it was around 240,000 patients that we
17 served. But, yes, we do receive PPS, but it comes from the
18 same block grant from Medicaid. So if they don't receive
19 the whole amount, one, they're going to diminish the amount
20 of patients that they receive, so we're also going to
21 receive less PPS rates. And, also, they will be uninsured,
22 so they will stay in the system, but we will get -- we will

1 have to get different funding sources to keep continuing
2 the services to service that population.
3 MRS. AVILA: And if I may add, also whatever we
4 are obligated or we cannot comply with also will bring us
5 to noncompliance with PROMESA and the fiscal board that is
6 added upon our fiscal realities right now.
7 Moreover, if we allow the system to collapse --
8 because this is not a -- when I started just coming here to
9 talk about the Medicaid cliff, we were talking about if we
10 confront the cliff, we will need to get out of prescription
11 drugs or we will need to get rid of the dental coverage
12 because it's an optional coverage, or 600,000 members will
13 get out of the health care system. That was at that time
14 that we were not confronting an exodus of the amounts that
15 we are looking at on the island after the hurricane. We
16 were confronting exodus during the past five years, but not
17 in the amounts of hundreds of thousands of lives.
18 My impression and with my experience of more than
19 20 years in the health care system, in the managed care
20 area, I have seen a managed care model that can show the
21 states how to do better managed care because with such lack
22 of funding, we have been knowing managed care for more than

1 two decades, we saw it getting into a chaos just pulling
2 our doctors to the edge, pulling our hospitals, even our
3 managed care organizations that everybody said that they
4 have a lot of money, that is not the reality in the island.
5 I have been looking at financial statements, utilization
6 trends, and I have been meeting with other managed care
7 administrators through the states. And when we talk about
8 the mechanisms that we have in place in our system, like
9 how we manage our PDL in terms of drugs, you know, that the
10 Government of Puerto Rico, we've seen the managed care is
11 the one who control all the drug administration by PBM and
12 PPA contracted by the government, not by the managed care
13 organizations. And we are the ones who deal with the
14 rebates and the pharmaceuticals. It's not an option that
15 we haven't tried in Puerto Rico in terms of managed care,
16 and right now I go to other Medicaid places and people ask
17 me, "How are you doing this? How are you doing these
18 operations? How do you deal with the managed care
19 organizations?" And we can show to do better managed care
20 businesses. But even with all those initiatives, it's not
21 any other alternative right now. I cannot get back to a
22 managed care organization and say you need to do whatever

1 you're doing with less money. That's the way we were used
2 to doing business in Puerto Rico. This is the budget.
3 This is what we can certify. Who is willing to work with
4 this type of environment? And people were doing it
5 because, as I told you, they like to be on the island. The
6 island has a way of enchanting the people, I will say. But
7 it has become a time that it's not possible. You cannot
8 pay a PCP, a generalist, a pediatrician $12 per visit.
9 That is not good medicine. You cannot have a surgeon
10 moving -- how you say? -- the tray and the patients to the
11 hospital to make the surgery. They don't have the staffing
12 to support them. Then you add, because of that, the
13 malpractices and the cost of those insurance. And the
14 people in Puerto Rico have the same costs or more to be
15 educated. So they have their loans. They have all these -
16 - all the complexities that a health system carries, and it
17 is not a matter of keep cutting things. If we need to cut,
18 we would need to say, you know what? No more health care
19 system as we know it. The government will need to do
20 drastic changes. We will not be able even to comply with
21 the federal government, even with nobody. We will need to
22 go to do medicine of the Third World. That's probably

1 sometimes you go and see things that you will get amazed.
2 But that is the reality of what we are facing right now,
3 and it's a matter of we used to have 18 months, we only
4 have like I would say less than a year to fix whatever
5 mechanism we can consider and give some continuance to the
6 program.
7 CHAIR THOMPSON: All right. Let's jump over to
8 Peter. We still have Kisha and Stacey who are waiting to
9 ask some questions.
10 COMMISSIONER SZILAGYI: Yeah, thanks for your
11 presentation. This is really disheartening and shocking,
12 every time I hear information about what's going on. To me
13 it's just a demonstration of if you have a fundamental gap
14 between the funds and the needs, the best MCOs, the best
15 providers, the best people just can't meet those needs.
16 Could you give a little bit more of a face for
17 the 1.2 million people? How many of these are children?
18 And how many of these are pregnant women? And out of the
19 900,000 who may lose health insurance, how many are
20 children and pregnant women?
21 MRS. AVILA: If you will allow me, I have Mr.
22 José Carlo. He's from Milliman. He's one of our assistant

1 actuaries, and he has those specific figures. I know
2 about, you know, average, but if he can answer, he will
3 give you a better -- a specific amount.
4 MR. CARLO: So the CHIP program, which is an
5 expanded CHIP program on top of Medicaid, covers around
6 86,000 children. In regular Medicaid there's around
7 340,000 children ages 0 to 20. And pregnant women, there's
8 about -- from our calculations, about 1,100 births on the
9 island each month in the Medicaid program, so extrapolate
10 that through a year. And I missed your other question
11 after pregnant women.
12 COMMISSIONER SZILAGYI: So is the estimate that
13 out of the 900,000 who may lose health insurance, that it's
14 pretty much the same demographics?
15 MR. CARLO: Yes. So I will mention that the
16 Puerto Rico Medicaid program also covers a population of
17 about 160,000 people in the commonwealth or state
18 population, which is above the Medicaid enrollment
19 requirements. So that would be the first population to be,
20 I guess, removed because it's not a federally required
21 population. And so that population has similar
22 demographics, although it has less children, because most

1 are covered through CHIP if they were not in the
2 commonwealth.
3 COMMISSIONER SZILAGYI: Okay. Thank you. And do
4 you know the percent of residents who are uninsured and
5 actually should be on Medicaid or CHIP?
6 MR. CARLO: I think that was in one of the
7 presentations, but it's a low percent.
8 MR. GONZALEZ: Yeah, Puerto Rico has very low
9 uninsured population. It's average 6 percent. Out of
10 those, how many should be? Hard to --
11 COMMISSIONER SZILAGYI: That's helpful.
12 CHAIR THOMPSON: So that's the total uninsured.
13 MR. GONZALEZ: Uninsured.
14 CHAIR THOMPSON: Not the eligible but not
15 enrolled.
16 MR. GONZALEZ: Total uninsured on Puerto Rico.
17 COMMISSIONER SZILAGYI: Okay. And the last
18 question: The 600 doctors or providers who are leaving,
19 can you give a sense for what -- how many are there in
20 Puerto Rico? What is the percentage?
21 MR. GONZALEZ: The percentage, out of those that
22 stayed?

1 COMMISSIONER SZILAGYI: Providers who are
2 leaving. You know, just sort of a general sense.
3 MR. GONZALEZ: Yeah, just so you get a sense,
4 Puerto Rico six years ago used to have about 11,000
5 registered doctors. Today it is about 9,000.
6 PARTICIPANT: Or less.
7 MR. GONZALEZ: Or less. We have lost about 2,000
8 providers. Actually, if you go to the Board of Medicine,
9 most of them are canceling licenses in Puerto Rico just
10 because they're moving out looking for better
11 opportunities, and the issue is the youngest one. And then
12 they train; they in the past used to come back to the
13 island. They're not coming back. They're training in
14 other places in the states, and they're staying there.
15 MS. AMADOR: And there's another issue that the
16 numbers are not -- they're estimated, because there's a lot
17 of doctors who are leaving the island but are keeping the
18 license in Puerto Rico open, active. So if they want to
19 come back, they can have it. So we don't really know, and
20 the Colegio de Médicos, the association that covers all the
21 doctors in Puerto Rico, they don't even know really the
22 numbers of how many doctors are really giving services in

1 Puerto Rico because that's the issue with the active
2 licensing and moving to the states. So it's around 7,000,
3 but it's just an estimate.
4 COMMISSIONER DAVIS: Thank you again for coming
5 all this way. It was just a really eye-opening
6 presentation, and I think for a lot of us, we knew it was
7 bad, but didn't know it was that bad. So I really
8 appreciate you being here.
9 I wanted to ask, just following up a little bit
10 more on Peter's question, specifically about primary care
11 and network adequacy since so many folks are leaving. One,
12 what is that starting to look like in terms of wait times
13 for patients, accessibility and being able to get into see
14 a primary care? And then also, what options are there for
15 bringing primary care providers back in terms of loan
16 repayment and other creative ways? Are there things in
17 terms of telehealth options to help with some of that
18 access?
19 MRS. AVILA: Well, we are doing -- we have been
20 doing a lot of initiatives towards those efforts.
21 Precisely those are ones of the main areas that are covered
22 by the new model. We are just, for example, guaranteeing

1 that the doctors are not going to have any reductions in
2 rates until September 2019, just to see how the situation
3 is developed, and most of them have approached us and
4 really they are waiting until next year to see how things
5 have been developed in terms of budget, in terms of fee
6 schedules and rates.

7 In terms of initiatives to do better primary
8 medicine and other alternatives to have some options for
9 the doctors, we think the model first we have now presence
10 of providers through the whole island. The beneficiaries
11 can move from the northeast to the west region and look for
12 providers across the island. That didn't happen before.
13 They were limited by regions and the access was more
14 complicated. That's one of the first options.

15 Also, we are dealing with high utilizer programs.
16 We are just doing treatment plans with case managers and
17 connectors in the community just to go and do, I will say -
18 - if I need to put it some way -- old medicine, when the
19 doctor used to go to your door and see how the family are,
20 home medicine, we are just trying to stimulate that in the
21 new model.

22 Also, the government has been issuing some laws

1 in terms of tax relief for the doctors, the specialists,
2 and they have that type of incentive. Also, we are working
3 with new laws to protect the doctors in terms of
4 malpractice medicine. And those are directly initiatives
5 that are in place right now just to try to persuade the
6 doctors to not leave the island.
7 Other supports that we are bringing to the
8 managed care organizations, for example, 92 cents of every
9 dollar needs to go to direct services. We are establishing
10 the MLR in the contract that never have been seen in the
11 states, 92 cents. These people were very, very happy with
12 me when we put that in the contract.
13 [Laughter.]
14 MRS. AVILA: But those are the extremes. That's
15 why I'm telling you that we have been looking for all the
16 options within managed care that are allowed, because
17 managed care have their restrictions, and we have been
18 putting in place just to take the program to the next
19 level.
20 Also, we have a lot of plans. We have been
21 developing a fee schedule for the dental practices. That
22 it was lacking of those comparisons.

1 And what we are doing with the managed care and
2 the professionals is when they cannot reach to an
3 agreement, we get in and we go and look for guidance. And
4 we look for reasonability in terms of negotiations. Even
5 in those lower areas that probably people will think there
6 is no space to negotiate, we don't have any other options,
7 and they need to look for a way to keep providing the
8 services until this gets more stable.
9 And the other thing that we have been just
10 improving, visibility with the IT systems. We are just
11 putting in place the MMIS, the Medicare fraud control unit.
12 We have been complying with all those requirements from the
13 federal government, and I can say today that CMS now has
14 visibility of what Puerto Rico is doing, where are the
15 services that are being performed, what is the cost of the
16 model. They have that already. They didn't have that on
17 January 2017. So, in two years, we have -- what we have
18 been working hand by hand with CMS just to cover all those
19 areas that were uncovered at the time that we getting the
20 administration, and those are many of the efforts.
21 Others we need to put more -- for example, we
22 have -- normal deliveries are decreasing because doctors

1 have a lot of risk just doing normal deliveries. We don't
2 have any of the drug that is used for less pain in normal
3 deliveries -- We say the epidural. It is not under our
4 coverage. So how can we incentivize the OB/GYNs to do
5 normal deliveries if they don't have those things in
6 coverage? So those are the things that we are changing in
7 areas that are needed to be adjusted in the short term,
8 just to keep some balance in the system in the meantime.
9 MR. GONZALEZ: If I may, just to follow up. When
10 we look into our access to care on the primary care level,
11 I think the system in general, it's okay at the primary
12 care level. Waiting times are usually lower.
13 We do have issues with certain specialists.
14 That, you know, a member, for example, to get an
15 appointment with endocrinology, it could take two to three
16 months. You're talking about diabetes patients.
17 Nevertheless, I want to call the attention to the
18 chart that I show because right now the older doctors are
19 the ones who stay in the system. That's going to change.
20 Unless something is done, in a couple of years, those guys
21 are going to retire, and what's going to happen is that
22 we're going to have a huge shortage of all sorts of

1 doctors, including PCPs.

2 I think at this point, we are okay when it comes
3 to access to PCP, but I'm very concerned with what could
4 happen in the next few years.

5 MS. AMADOR: I would like to include also that we
6 have to -- with the issues that the new system, electronic
7 medical records and some additional requirements, a lot of
8 older doctors are shutting down their offices and coming to
9 the FQHCs to work with us, and also you have to put into
10 perspective why the research doctors are leaving, because a
11 generalist salary in Puerto Rico is around $80,000. If you
12 compare to the States, that is 175- to $200,000-plus. So
13 there is just a big difference just in the salary if they
14 decide to come to the Mainland.

15 Also, we try to retain them with the FTCA
16 insurance, the federal coverage, so they don't have to
17 spend more money on their coverage.

18 The loan repayment programs that we have as
19 federally qualified health centers, we pay them quality
20 incentive, retention balances. We pay them all the
21 licensing they need to provide services. We provide them
22 additional staff, staffing, so they can concentrate in

1 working with the patient and not feeling all the
2 recommendations, all the other things they probably need to
3 spend time on that.
4 So for us as federally qualified health centers,
5 we have to rethink on the ways we can retain doctors
6 because they are the ones who allowed us to bill for our
7 services. If we don't have doctors, we don't have billing,
8 so we don't have any revenues or any money. So we have put
9 in a lot of investment in our doctors, even giving them the
10 opportunity to work less based on production. So, as soon
11 as they finish their patients, they can leave early to
12 their houses and have more time.
13 Also, another way that we are retaining doctors
14 is having additional contractors within our system to cover
15 lack of doctors in certain areas.
16 Also, as Angie and Orlando says, specialties are
17 very difficult to find. Appointments sometimes get to four
18 or five months. So we are starting to contract and have
19 specific specialties in our centers, such as
20 endocrinologists, gastroenterologists, pulmonologists,
21 neurologists, cardiologists, internists in our facilities,
22 so they don't have to go outside or they don't have to wait

1 a long time for an appointment.

2 CHAIR THOMPSON: We are already just a little bit
3 past our time, but I'm wondering if you can just stay with
4 us for a few more minutes because we've got a couple of
5 other Commissioners who would like to ask some questions.

6 MS. AMADOR: Yes.

7 CHAIR THOMPSON: We want to take advantage of
8 your being here to make sure that we cover the issues that
9 we're interested in.

10 So I've got Brian, Toby, and then I'll wrap up.

11 COMMISSIONER BURWELL: So I'd like to build upon
12 some of the graphs that you provided, Orlando, around the
13 high incidence of chronic conditions in Puerto Rico and the
14 relation of that to access to prescription drugs and the
15 high cost of prescription drugs. Could you just talk about
16 are people not getting access to the kinds of drugs that
17 could manage these conditions, and how much of it is
18 access? How much of it is compliance? Are people getting
19 the medications that they should be getting to manage
20 these, these illnesses?

21 MRS. AVILA: In terms of covering medications, we
22 are taking care of our patients, have the treatment up to

1 date. That's -- right now, that is not the main problem.
2 It was we have the resources to continue until 2019 with
3 the $4.8 million -- billion dollars that were assigned to
4 us as 100 percent parity.
5 So the operations are still stable right now.
6 People are getting their treatments and their services, and
7 moreover, with the new model, what we have done is to
8 identify the high-cost, high-needs populations. And we
9 identify the population, and we have -- implement an
10 structure of payment by the rates, not by the capped
11 premium amounts. We changed that to pay by the
12 classification of those patients, and we will pay more for
13 a cancer patient, that for a healthy member in the system.
14 That way, we are just assimilating the specialist and their
15 managed care organizations to bring us treatment plans,
16 specific treatment plans for those types of high-cost,
17 high-needs populations. And that assures us that that
18 patient will -- we will ease their life just giving
19 services, and we are trying to put all those services in
20 multidisciplinary settings, and they will be provided by
21 the drugs that are available for that treatment and a very
22 focused treatment for that type of diagnosis.

1 And that's the way we have been approaching this
2 in this new contract. I don't know if Orlando may add
3 something.
4 MR. GONZALEZ: Yeah. No, I agree at the drug
5 side. It's really not the issue. Patients are getting
6 their medication. Actually, you see the access in Puerto
7 Rico and because of the concentration of high number of
8 patients, poor patients with chronic conditions we get, a
9 patient in Puerto Rico gets about 55 drugs a year on
10 average versus in the States, it's about 40.
11 So Puerto Rico, in terms of drugs, the access to
12 drugs, the problem is that treating chronic conditions is
13 more than just the medications. You need centers of
14 excellence. You need nutritionists in the case of
15 diabetes. You need to deal with other professionals. You
16 got to deal with social workers because many of these
17 people have a lot of conditions on environment, so-called
18 "social determinants of care," but in reality, it's people
19 that have poor nutrition habits. They don't have
20 transportation in order to get to their appointments
21 sometimes. They don't have the support of family members.
22 In order to create the infrastructure to serve

1 those chronic patients in a comprehensive way, the way that
2 it should be done, there's no resources. So the drugs are
3 covered, but that's not enough to really keep their
4 conditions under control.
5 COMMISSIONER BURWELL: Thank you.
6 COMMISSIONER DOUGLAS: Just a quick final
7 question. Back on federally qualified health centers, I'm
8 wondering with HRSA if there's any investments or special
9 funding that HRSA has been doing to invest in access
10 points.
11 MS. AMADOR: Access points are being opened.
12 Every year, in Puerto Rico, there's new access points.
13 HRSA has given us a lot of money in the last two years,
14 especially for Zika issues in Puerto and now for the
15 hurricane recoveries and emergency preparedness and also
16 for behavioral health. There's big issues with opioids and
17 mental health issues also on the island, so we're receiving
18 funding from them.
19 But we keep the same funding amounts we have been
20 receiving the last years. So if there's no supplemental
21 funding, we are being in the same base grants that we
22 received in the last years.

1 CHAIR THOMPSON: Okay. I have just a couple of
2 last questions. So one is I'm going to build off of where
3 you were going, Toby. As I think about this and the story
4 that you've told us today and the information that you
5 brought, our charge is to talk about long-term
6 sustainability, but there's a few steps that you have to go
7 through to get to long-term sustainability.
8 You first have to stabilize the system in crisis,
9 and then you actually have to strengthen it, so that it can
10 perform successfully. And then you have to set the
11 conditions for ongoing performance. So I think before we
12 get to sustainability, we have to maybe think in terms of
13 some other buckets.
14 And I'm not sure that I totally have the picture,
15 and I just want to invite you to comment on this, otherwise
16 we'll just load this all on Kacey to solve the problem for
17 us -- about where all the other streams of funding are in
18 terms of filling in the picture so that we understand from
19 a Medicaid and CHIP standpoint what is it that we need to
20 contribute and where are the dependencies for other
21 contributions and investments, whether from other federal
22 programs or other sources, including the private sector or

1 other sources, so that we understand.

2 I mean, those dependencies, for example, on

3 workforce, there's only so much that Medicaid and CHIP is

4 going to be able to do in terms of solving that problem,

5 but if we're developing a funding approach and a financing

6 approach that's dependent upon some other investments and

7 some other results with respect to attracting workforce and

8 retaining workforce, then we need to have that in mind as

9 we think about what the success of our approach is.

10 So one is to understand where those other

11 investments are needed, what the sources are associated

12 with those, and how it fits into what we would be

13 suggesting that Medicaid and CHIP do.

14 And then the other is I'm not sure that I totally

15 understand how the Fiscal Oversight and Management Board

16 fits into all of this. So I think I need a little bit

17 better sense about that contextual environmental and what

18 either opportunities or constraints that provides as we

19 think about what we could suggest.

20 But some of this is just understanding our place

21 and the larger context, and so any general comments or

22 directions that you would like to provide to us to

1 consider?

2 MRS. AVILA: I would like to start in that

3 matter, and thank you for the opportunity because always I

4 would like to speak about these topics for a long time.

5 And today, it is possible for me and so thank you, and bear

6 with me. It's a language barrier, and I try to be as clear

7 as possible.

8 In terms of how we can identify other

9 opportunities with the agencies, we work closely with CMS,

10 HHS, and HRSA. Like in any place, sometimes when you work

11 with the government and sister agencies, the communications

12 sometimes can be better, and we can do some planning on how

13 to interface with all these grants.

14 And, for example, we have the federally qualified

15 health centers. They have their own funding assigned by

16 HRSA, but the government, the local government needs to do

17 a wrap-around payment and some commitments to that effort.

18 And this has been difficult to get to some

19 collaborations and to maximize the funding because right

20 now, as Ms. Amador is saying, if the federally qualified

21 health centers cannot comply, they lost their grants, but

22 if the local government cannot make the wrap-around

1 payments, they are going to be in noncompliance as well.

2 The wrap-around payments has been a financial

3 constraint and challenge for Puerto Rico. We are talking

4 about we expend more than $120 million a year in wrap-

5 around payments. So the local government needs to identify

6 those resources to be able to comply and have the federally

7 qualified health centers on top. It will be great for them

8 to have a full grant. That would be a dream come true, but

9 that is something that we will need to work with HRSA.

10 On the other hand, with CMS, we are in a

11 reimburse program, but even doing all the same things and

12 complying with the same requirements, Puerto Rico always

13 needs to wait longer to have the grants assigned, longer to

14 have the authorizations, and that causes us a lot of

15 problems, even with the organizations that have a sense of

16 what is happening, Puerto Rico is not complying, is doing

17 things that are not accordingly, and it's none of that.

18 It's only that we are complying with some requirements, and

19 the federal government in those offices have their lack of

20 resources as well as Puerto Rico.

21 We have two persons only assigned to review a

22 whole implementation of a new model. They ask us for 60,

1 90 days, until we can ask for reimbursement in those
2 programs. That doesn't happen in other states or
3 territories. Why? I always ask why because you heard
4 there is a lot of mismanagement. If they say that Puerto
5 Rico has a lot of waste, fraud, abuse, my numbers doesn't
6 say that, and we have come to get used to those type of
7 criticisms. And it's not that we are denying or accepting.
8 It is the facts are that the numbers doesn't show those
9 behaviors, and we have been penalized for that.
10 And it's very frustrating just to work from sun
11 to night because we don't stop working. That's the reality
12 because this is not a story. This is real, seeing an
13 island of more than 4 million people just getting depleted
14 every year, and seeing that my people is in this state. We
15 have more than 6 million Puerto Ricans in the States.
16 And you know what? They want to live on the
17 island because we like to live in the island, and I have
18 been seeing that -- I'm sorry. But you're seeing that is
19 happening in a slow pace, and it has become the time that
20 nobody is looking. But the island in two years probably
21 will have 2 million people, and the Puerto Ricans aren't
22 going to be living here. And it's going to cost a lot, and

1 it's going to be a lot of situations.

2 So if CMS and HHS and HRSA, if we really put our

3 efforts together, I know we can accomplish better things

4 for the island, and we have to support and everybody have

5 great intentions. But at the end of the day, I am still

6 from October 31st and I'm -- like today is December 13 or

7 14 -- 14, and I haven't had the authorization for Puerto

8 Rico to move ahead with the new system.

9 And you know what I need to stand in the island?

10 Ah, it is because Puerto Rico is doing wrong things or

11 things in closed doors, and it's doing -- and it's not

12 going hand by hand with the federal government. And that's

13 not true people, and that's what they heard there. And

14 that's how the noise start, just develop, and it ends like,

15 oh, Puerto Rico is corrupted or is doing something bad

16 because it doesn't have the money. And that is not the

17 reality.

18 We have been complying with all the agencies. We

19 have been presenting for my projections, and nobody

20 listens. And that's the -- what we are just living day by

21 day.

22 On the other hand, talking about the fiscal

1 board, the fiscal board doesn't allow us to include any
2 number in a projection if I don't have the certification
3 from the federal government. We used to do our projections
4 based on what CMS was announcing and what the Congress was
5 putting aside for Puerto Rico, and I cannot include any
6 projection because I don't have the document that said that
7 it's going to be for Puerto Rico and is certified. And that
8 is part of our daily -- everything that we do, every
9 contract, every negotiation needs to be approved by the
10 fiscal board in advance. Even though we have the grant,
11 even though we have the certification, they need to
12 approve.

13 And you know what? They have been approving
14 because I have been personally with the governor, with the
15 health secretary of Puerto Rico, with our resident
16 commissioner, going in front of them and saying, "Do you
17 know what? If we don't have a healthy population, we are
18 not going to be able to bring the economy to the place that
19 we can cope with what has happened."

20 You know what as well? That we came to this
21 point because Puerto Rico didn't bring the message
22 correctly. Puerto Rico was getting to negotiations to

1 allowing, just accepting on funding to keep a system that
2 was not at that price, and nobody said in the Congress and
3 stated that. And that's why our doctors were just
4 receiving less money, and we get used to that. And that's
5 why I'm telling you there is no more room and space to keep
6 that pattern. We need to change that pattern with
7 evidence, with real information, with people that can talk
8 the same language. That's what we have been doing these
9 two past years, just putting the health together and
10 bringing that message to you.
11 CHAIR THOMPSON: Thank you very much.
12 Again, this has been extremely helpful. I think
13 everyone has benefitted tremendously by having you here
14 with us this morning. We appreciate your indulging us and
15 our questions and staying past time.
16 Let me just see if there's any public comment
17 that anyone would like to make before we take a break, and
18 then we'll come back for more Commissioner conversation on
19 this subject.
20 Just come to the microphone, please.
21
22 **### PUBLIC COMMENT**

1 * MR. CINTRÓN: Good morning. My name is Allan
2 Cintrón Salichs. I'm the executive director of a federally
3 qualified health center in Puerto Rico, Consejo de Salud de
4 Puerto Rico Inc. I'm also the president of the board of
5 the Puerto Rico PCA Association. I do have some exact
6 numbers here of the number of physicians that have left the
7 island since 2009-2014, which I'm going to read for you.
8 In the time frame comprised between 2009-2014,
9 the total number of physicians available in Puerto Rico
10 dropped from 13,452 to 11,888, which is equivalent to 472
11 physicians per year or 1.29 physicians per day. This is a
12 reduction of 17.5 percent, according to the statistics
13 supplied by Customer Researching in December 2014. Most of
14 these were specialty physicians. As a matter of fact, the
15 number of specialty physicians dropped from 8,452 in 2009
16 to 6,713 in 2014, which is equivalent to 347 specialty
17 physicians, almost one per day. Those are the true numbers
18 in Puerto Rico. It is a dramatic situation.
19 I think all that has been discussed here is not a
20 matter of challenging whether the plenary powers of the
21 Congress over Puerto Rico, but it is about the people of
22 Puerto Rico. This is the government of the people, for the

1 people, and by the people.

2 So we do have a problem here in Puerto Rico. We
3 are required to comply with all federal laws, but we don't
4 receive the same amount of funding. There is a disparity
5 there that needs to be taken care of.

6 According to the Fifth Amendment of the
7 Constitution of the United States, we are to have equal
8 protection of the laws. Under the Medicaid law, we are
9 simply not having the same protection. I think that is a
10 problem that has to and needs to be addressed at some
11 point. It's an old, old, very old problem, and in the case
12 of Medicaid, Medicare, CHIP, it's about life. People are
13 simply dying in Puerto Rico. We see that our health care
14 center will delegate access to services because they can
15 afford it, because we don't have enough funding because we
16 don't have the medical physicians, the specialists, to take
17 care of. As Orlando said before, it could take you three,
18 four, even five months to see an endocrinologist in Puerto
19 Rico. That is not good medical practice.

20 Thanks.

21 CHAIR THOMPSON: Thank you. And, also, if there
22 are any data that any of the public think can be useful to

1 us, I just want to encourage you to go ahead and just --
2 you can get our contact information through the website and
3 send that on to us. Having the sources and the citations
4 helps us as well, using that information.
5 MS. LULINSKI: Good morning. My name is Amie
6 Lulinski, and I'm the project manager for a longitudinal
7 research project called "The State of the States in
8 Intellectual and Developmental Disabilities." The question
9 was raised asking about the number of pregnant women and
10 children that this impacts. I would encourage the
11 Commission to also consider the number of people with
12 disabilities this impacts, particularly people with
13 intellectual and developmental disabilities, those who are
14 medically fragile and those who are technology-dependent.
15 And the second comment that I would like to make
16 is I am so very glad that this is being brought up in this
17 kind of forum about the conditions of Medicaid in Puerto
18 Rico. I would also encourage the Commission to consider
19 the situations in the U.S. Virgin Islands, Guam, American
20 Samoa, and the Commonwealth of the Northern Marianas
21 Islands.
22 Thank you.

1 CHAIR THOMPSON: Thank you.

2 MR. LAWS: Good morning. My name is George Laws.
3 I'm the deputy director of the Puerto Rico Federal Affairs
4 Administration, which serves as the Washington, D.C.,
5 office of the Governor of Puerto Rico, Ricardo Rosselló.
6 We greatly appreciate the opportunity to have MACPAC hear
7 about this issue in greater detail, and in response to the
8 question about the broader context of federal funding that
9 can be brought to bear, I would like to bring the attention
10 of the Commission to a requirement that Congress
11 established as part of the Bipartisan Budget Act, which is
12 for the Government of Puerto Rico to present to Congress an
13 economic and disaster recovery plan. That economic and
14 disaster recovery plan is a comprehensive plan that
15 establishes a number of different areas of capital
16 investments that need to be addressed as part of the
17 recovery and reconstruction process. That plan was
18 submitted by the Government of Puerto Rico to Congress on
19 August 8th. I've shared a link to the document with Kacey
20 over email just as we had that question come up because I
21 thought it would be a very useful context for all of you to
22 have. And one of the areas of capital investment, of

1 course, is health care and our health industry, so I would
2 greatly encourage MACPAC to also utilize that context when
3 it's doing its analysis for the stabilization as well as
4 kind of the long-term sustainability question for Puerto
5 Rico's Medicaid but broader health care system.
6 Thank you.
7 CHAIR THOMPSON: Much appreciated. Thank you.
8 MS. HEREDIA RODRIGUEZ: Good morning. My name is
9 Carmen Heredia Rodriguez, and I am a reporter, and before I
10 start, I want to make sure that it's okay for a reporter to
11 ask questions.
12 CHAIR THOMPSON: Sure. You're a member of the
13 public.
14 MS. HEREDIA RODRIGUEZ: Great. Thank you. I
15 appreciate it.
16 [Laughter.]
17 MS. HEREDIA RODRIGUEZ: So Ms. Avila in her
18 presentation mentioned that continued money from Congress,
19 in addition to the $4.8 billion, would enable Puerto Rico
20 to be able to provide certain services like long-term care
21 that's not being provided now.
22 Another service that I'm curious about is

1 providing curative hep C medications through Medicaid. I
2 know that Medicaid here in the states has fought and in a
3 lot of states won to provide those. So I'm curious to
4 know, first of all, whether Medicaid covers curative hep C
5 medications, and if not, if there are any plans to use the
6 $4.8 billion that they received from Congress in order to
7 provide that new coverage.
8 CHAIR THOMPSON: Thank you. Normally I will say
9 we don't -- it isn't so much a matter of asking questions
10 but taking in public comment. But, Angie, if you are
11 interested in responding to that, I encourage you to do
12 that, or you can do so after the meeting.
13 MS. HEREDIA RODRIGUEZ: I appreciate it. My
14 apologies.
15 MRS. AVILA: Well, it is a short answer.
16 Hepatitis C is covered for the HIV patients, and now Puerto
17 Rico is doing the identification of the funds to include
18 hepatitis C for all the patients in coverage.
19 MS. HEREDIA RODRIGUEZ: Thank you, Ms. Avila.
20 CHAIR THOMPSON: Okay. Thank you.
21 Again, many thanks to all of the public and to
22 our panelists. We appreciate your coming and spending

1 time. We appreciate the future help we will no doubt call
2 on you to provide as we continue to investigate this issue.
3 We will take a short break. We are a little bit
4 behind time, but let's take 10 minutes and come back just
5 about five of 11:00 to pick up our conversation.
6 * [Recess.]
7 ### **FURTHER DISCUSSION OF MEDICAID IN PUERTO RICO**
8 * CHAIR THOMPSON: Okay. Again, Kacey, thank you
9 for all the work you did in preparing for that panel
10 discussion. It was, I think, extremely useful.
11 We are a little bit behind time so here's what
12 I'm going to suggest. I think there were a number of
13 questions and areas of exploration that came out in that
14 conversation that I think, Kacey, you have made note of in
15 terms of thinking about how do we pursue or explore some of
16 those areas. What I want to do is give the Commissioners,
17 you know, an opportunity to add to any points that weren't
18 discussed in our last session, in terms of areas that you
19 think we need to kind of add to the list of things that
20 we're interested in or we think, hearing the conversation,
21 really need priority in terms of exploration. And I then I
22 think we'll go ahead and sort of organically just catch up

1 on our time that way.

2 Toby and I were just having a little bit of a
3 back-and-forth, that both of us were actually wondering
4 also about Medicare. We didn't get a chance, really, to
5 get into that part of, again, sort of this contextual piece
6 about, you know, where all the places where we need to have
7 at least an understanding of where federal money is coming
8 into the system, or other kinds of money are coming into
9 the system. Both Medicare beneficiaries, generally, and
10 what's happening to them in the system, and then duals.

11 MS. BUDERI: I can try to answer that question.
12 I'm not as familiar with the Medicare side, obviously. I
13 think there are some issues with federal treatment under
14 Medicare that affect Puerto Rico. One of the things that
15 was also a contributing factor here, because Puerto Rico is
16 very reliant on Medicare Advantage, they were
17 disproportionately affected by cuts to Medicare Advantage
18 over the last several years. I think there are some things
19 in the way the Medicare DSH formula works, that affect it
20 because of its -- because of the SSI factor and Puerto Rico
21 not participating in SSI. So that's a little bit uneven.

22 I know there are about 250,000 dually eligible

1 beneficiaries, so it's a pretty relatively high percentage.
2 Beyond that I can't tell you much today but I can
3 definitely look into it and see how it plays a role.
4 COMMISSIONER BURWELL: But spending for duals was
5 probably much lower in Puerto Rico because of the lack of
6 coverage for LTSS. So it's mostly --
7 CHAIR THOMPSON: Right.
8 COMMISSIONER BURWELL: -- copays and deductibles.
9 CHAIR THOMPSON: Martha, you were going to jump
10 in, and then I think, Phil, did I see --
11 COMMISSIONER CARTER: I was actually -- yeah,
12 changing the subject a little bit, I mean, it's clear this
13 is a real crisis. I mean, I think we all feel that.
14 I was looking through the Puerto Rican Health
15 Center rollup data and I'm struck by a couple of things.
16 Ninety-nine percent -- this is was in the presentation --
17 99 percent of their patients are under 200 percent of
18 poverty. That's higher than any place else.
19 They don't currently, or maybe they're just in
20 the process, I think Gloria told me, of creating mechanisms
21 to have -- nurse practitioners and physician assistants,
22 they actually don't have that workforce. They don't have

1 that in Puerto Rico, and nurse midwives, or at least not in
2 the health centers, and it doesn't seem like they have much
3 in Puerto Rico at all. So to your point, most of their
4 physicians are GPs rather than family practice, and they
5 don't have that additional level of workforce that's
6 available to the rest of us. So that might be something to
7 consider, even recommending, that that would help them.
8 The other thing that jumped out at me is a lot of
9 their quality metrics have gotten worse over the past year.
10 Makes sense. Their low birth weight rate -- I have to
11 always do that slowly -- their low birth weight rate has
12 gone up over the past year. So, I mean, we definitely have
13 an impending health crisis. I mean, it's financial but it
14 shows in these numbers that I'm looking at, so I think it's
15 really important.
16 CHAIR THOMPSON: Thank you. Bill.
17 COMMISSIONER SCANLON: I'm going to say, as I
18 said it in the hall, that I agree with you that there's a
19 question of what should be done about the short-term crisis
20 and in thinking about that in the broad context, and then
21 what needs to be done in the longer term, also in the broad
22 context of some of the factors may change.

1 In that longer-term consideration, I think that
2 some examination of what maybe a good FMAP might be, as
3 opposed to the current formula that we have, and I say that
4 having sort of been involved with work on the FMAP, where
5 you think of sort of three factors. You think of a state
6 or territory's ability to pay, the need for care sort of in
7 that area, and then the third thing being the cost of care,
8 which we raised -- which was discussed a little bit
9 yesterday.
10 And so now what would be -- the proposal we heard
11 this morning was, you know, to revert to the current
12 formula, after 2021, but I think that we think about it
13 sort of as maybe an opportunity to start to consider what
14 might be some adjustments to that current formula.
15 And then the last thing I would say is that the
16 territories should be looked at sort of in their entirety,
17 because I don't know if there's any situations on a longer-
18 term basis, in any of the territories, that deserve
19 attention from us, from a Medicaid and CHIP perspective.
20 CHAIR THOMPSON: Kit and then Sheldon.
21 COMMISSIONER GORTON: So I agree with Bill
22 wholeheartedly, on the last piece. We shouldn't just look

1 at Puerto Rico. The Virgin Islands got hit as badly with
2 the hurricanes as Puerto Rico did, and Guam just got
3 walloped. So, you know, I think that we should broaden our
4 aperture to cover all of the territories.
5 I'm struggling a little bit because we talked a
6 lot about numerator numbers and we didn't have a lot of
7 denominator numbers. And so, okay, so we've dropped X
8 thousand physician providers. What's the population done
9 in that period of time? So I just -- I want to make sure
10 that we're in context and that what we're thinking about in
11 terms of sustainability is not the situation on the ground
12 five years ago but the situation that's likely to be on the
13 ground in the next 3 to 5 to 10 years. So that's one
14 point.
15 The second piece, and I talked about this a
16 little bit the last time, is I do think we need to have the
17 right context as we look at these numbers. So we heard
18 outrage expressed because it might take four or five months
19 to get an endocrinology appointment for a person with
20 diabetes. I'm here to tell you that if you could get an
21 endocrinology appointment for a person with diabetes in
22 Fairfax County, Virginia, in four to five months, you would

1 be feeling really good about having been able to do that.
2 So it's very important that we -- I'm not
3 diminishing, at all, the pain and the stress and the
4 difficulties that these folks encounter, but they are in
5 this and they don't necessarily have a perspective about
6 what it's like everywhere else. And I think the other
7 piece of context is if we're going to talk about what we're
8 paying people, then again we need to have benchmarks. A
9 general practitioner, quite frankly, can't get into most
10 managed care networks in the States because they lack the
11 qualification of being board certified in a specialty. But
12 if you're a board-certified specialist in a primary care
13 specialty, in a managed care network, I don't think many of
14 them are making $200,000 a year.
15 And so, you know, we know what the salaries for
16 those are in the States, and we need to be sure that what
17 we're coming is apples to oranges. So I just think that
18 it's important. I think the numbers they brought us are
19 illuminating. But as we put together our recommendations
20 for Congress I think we need to say, you know, the data are
21 available in terms of comparative cost of living. The data
22 are available in terms of other things. I think it's

1 important that they pointed out that they're subject to all
2 of the same requirements that everybody else is, and that's
3 a problem because I'm not -- I'm reasonably confident,
4 based on what we've been shown, that they're not receiving
5 a level of federal funding to support their compliance with
6 the federal requirements. So I don't have any quibble with
7 that.

8 But I think as we think about the longer-term
9 sustainability piece we really need to come back to, you
10 know, what's the target here. You know, what is a
11 reasonable aspiration? And that should inform our thinking
12 about what the right FMAP is and some of these other
13 things.

14 CHAIR THOMPSON: Let me just comment on the
15 question of the right FMAP and whether or not that's
16 something we -- I mean, I think there's a question about --
17 and maybe, Anne, you want to jump into this in terms of
18 what the request is from a standpoint of timing, if nothing
19 else. I mean, because this is a subject, as we've seen,
20 that we can ask a lot of questions, and even think about
21 broadening, as we've all discussed, broadening the question
22 to include a consideration of what's happening in the

1 larger economic environment, or what's happening with other
2 federal streams, or even potentially we talked before about
3 how does this compare with things that are happening in
4 other states and territories, as an understanding.
5 And then thinking about the shorter- versus
6 longer-term question, are we aiming towards a
7 recommendation, as a question, right? I mean, should we
8 make a series of recommendations? That lift is pretty
9 substantial for us to go through the process to be able to
10 do that. It still might be worth doing. It may be that we
11 want to do this in a couple of steps, where the first thing
12 that we'd want to do is we'd want to lay out our
13 understanding of the issues and the problems and the
14 challenges, and perhaps some areas of general commentary or
15 observation, where we think there might be some
16 opportunities to shape something differently in terms of
17 program requirements, in terms with relationship with the
18 Federal Government, in terms of how the funding flows, in
19 terms of how different streams of funding are brought
20 together, et cetera, et cetera, with an idea that that
21 maybe provides a launching-off point for something further
22 down the line or not.

1 I just don't want us to get too -- I don't want
2 us to presume that what we're after, unless the Commission
3 decides that it really has the appetite to do that and the
4 wherewithal to do that, that we're going to come up with
5 something that is a series of recommendations that includes
6 something as precise as what is the FMAP. I just think
7 that's a question about where we're aiming.
8 So I have Sheldon and then Alan and then Fred,
9 and then Bill.
10 COMMISSIONER RETCHIN: I'm actually sensitive to
11 what Kit raised. I don't -- I mean, I asked Kacey about
12 physician density figures so that we can normalize this,
13 and recognizing that is it even a different population in
14 the island than on the mainland, because it's overwhelming
15 Medicaid. So if you looked at the Medicaid mainland
16 physician density I would say it's probably, or was, pre-
17 hurricane, worse.
18 That said, here's where I guess I'm struggling is
19 it's really moving fast. So there is this cliff that's
20 ahead of us, and I think the longer that Congress waits on
21 a decision, whichever way that decision is, that more will
22 transpire and will it cost more?

1 What I don't understand is why isn't Florida, why
2 isn't Governor Scott screaming about this with a cost so
3 high on the out-migration? And then a fundamental question
4 for me is, if we were to fix it, or if we were to help stem
5 the tide, is the out-migration of providers and people, how
6 much would that help? We're not going to be able to cure
7 world hunger, but my sense is that we might be able to
8 divert away from a humanitarian crisis and be able to help.
9 And maybe, actually, on -- and I know it's not
10 scored this way, but with all the out-migration now, which
11 doubled after the hurricane, by the way, that we might be
12 able to help that and, in the end, save a huge amount of
13 money for the Federal Government.
14
15 COMMISSIONER WEIL: I agree we need to take the
16 scope of what we want to try to do, take that on carefully.
17 I want to just put two bits of context. One is
18 we jumped into the issue of Arkansas disenrolling 4,000
19 people a month in a way that made some people not so, you
20 know, thought it was -- questioned whether that's our role,
21 but it was important. I realize this isn't exact but the
22 lawyer in me has to always go back to the statute. We're

1 supposed to have an early warning system to identify other
2 factors that adversely affect or have the potential to
3 adversely affect access to care by, or the health care
4 status of Medicaid and CHIP beneficiaries. It's pretty
5 hard for me to listen to this and think that we haven't
6 identified something.

7 So again, I don't want to try to solve every
8 problem. I completely agree. I have more questions than
9 answers. But the notion that sort of we've been warned, I
10 feel like we've been warned. So I just put that out there.

11 CHAIR THOMPSON: Which I think also -- I mean,
12 that's something for us to seriously talk about in terms of
13 the ability for us to shine a light on a set of issues by
14 having a certain kind of information put together in a
15 certain kind of context, again, without necessarily aiming
16 towards we know what all the right answers are, is maybe
17 something that is worthy, in and of itself, over the
18 shorter term, and maybe then sets up the stage for, you
19 know, continued work and ideas about things that can help
20 solve that on the longer term.

21 Fred and then Bill.

22 COMMISSIONER CERISE: So, you know, there is a

1 bigger picture that I'm not sure we understand that --
2 maybe Bill does -- your comments about the territories and
3 how those are treated differently, because before the
4 hurricane there was a big difference in what Puerto Rico
5 had access to in Medicaid, with a smaller rate match than
6 you would have expected in a cap, and that sort of stuff.
7 So in one sense, if they just had the same deal
8 that Mississippi had, for instance, then it seems like that
9 would address the issues there. So I don't understand, you
10 know, the issues behind different territorial treatment,
11 nor am I asking us to get into that, but there is a much
12 simpler -- I mean, I don't think we can address that but we
13 could comment on this is what it takes to run a Medicaid
14 program for a population that looks like this. It seems
15 like that would address a lot of the issues.
16 So I don't know. Like I said, how do you
17 separate those issues? But we can certainly say this is
18 what Medicaid would look like, or should look like for this
19 population.
20 And I'll just make one other comment about
21 recovery, and that is, like others, I like the data, you
22 like to be data-driven, you like to understand sort of how

1 many per of everything that we have and need. In the midst
2 of recovery, and even after immediate short term but sort
3 of intermediate term, you're going to have to accept some
4 mismatches, just because people don't -- things don't
5 happen in order, you know. And so you lose providers
6 because they can't stay and do their business, and then
7 even though the population goes down you still have a
8 population but you lost, you know, your one specialist, and
9 so you have a big mismatch.
10 And so I think in the intermediate term,
11 certainly, I think we need to be comfortable with some
12 mismatches in providing some assistance that, you know,
13 might be more than the numbers justify.
14 CHAIR THOMPSON: And Fred, you have special
15 insight on this dynamic, and so I really appreciate that
16 warning, that we may not be able to have a sort of full
17 view into how all the pieces are going to fit together in
18 the right way so that everything comes together, that it's
19 going to be, well, this is the best we can do to get this
20 going, and to get this better, and then, in the meantime,
21 we'll try to fill in over here, and so forth. I think
22 you're trying to make sure that we don't try to make

1 everything to kind of policy-wonk perfect, from that
2 standpoint. Okay. Not that we don't love our policy
3 wonks.
4 Bill and Brian, and then we'll bring everything
5 to a close.
6 COMMISSIONER SCANLON: Yeah. I just wanted to
7 say, I'm kind of much aligned with Kit, I mean, and that
8 was in some respects motivation behind my comment. So it
9 was not to think about we're undertaking an FMAP study or
10 we're leading to a very specific recommendation.
11 When you look at what's happened historically
12 with the territories it's clear Congress made choices.
13 They're not formula-driven choices, and I think that it
14 would be useful here to provide information, that as they
15 think about more choices or new choices, that they have
16 information about how things might stack up relative, sort
17 of, to alternatives. And that would be -- that's much
18 short of the work that I think would be required to try and
19 open up the FMAP and make a very specific recommendation.
20 CHAIR THOMPSON: Okay. Brian and then I want
21 Anne to circle back in on the question of the other
22 territories.

1 COMMISSIONER BURWELL: I raised this last time
2 and I'm not really advocating for this, necessarily. But I
3 would propose that we think of fairly dramatic changes to
4 the Medicaid insurance model in terms of coming up with
5 solutions. I mean, it is a significant problem that may
6 require pretty radical differences, and there already are
7 some differences. I mean, like one thing around the FMAP
8 that, you know, in other states we pay federal income taxes
9 and we get federal money back. In Puerto Rico, they don't
10 pay federal income tax. So it is much more of a grant
11 program. So that's just one thing.
12 And also, some of the other things, you know, if
13 it's just a major 1115 or whatever, getting around the
14 Medicaid best price thing, if it's a non-Medicaid program
15 then it doesn't have to comply with that, or all the
16 Medicaid requirements and administrative oversight. You
17 know, we may want to just propose a model that's just a lot
18 simpler in terms of federal-state interaction and
19 administration.
20 So I think we should be fairly kind of creative
21 and bold in terms of -- I'm not saying that's the answer,
22 but I think we should at least investigate fairly radical

1 changes.

2 CHAIR THOMPSON: I don't know about

3 characterizing it as radical, but Toby and I were talking

4 along the same lines. You may be just going further with

5 that, in terms of where are there opportunities to

6 streamline, to unify, to alleviate burden, to increase

7 agility between the federal and the territory government,

8 in terms of how to proceed.

9 So I think -- in fact, I think we heard some of

10 those potential pieces of opportunities, and we've

11 discussed other areas, as a Commission, in the program writ

12 large, where we think maybe there might be some

13 opportunities to test out here.

14 So I think there's that whole range of, you know,

15 possibilities, from very pointed ideas about here might be

16 some particular areas where we want to make some

17 adjustments and the commonwealth's responsibilities, vis-à-

18 vis Title 19, where a few surgical places of relief would

19 make a big difference versus, you know, something more

20 wholesale.

21 But I think that's right. That needs to be on

22 the table in terms of thinking about program structure and

1 administration.

2 COMMISSIONER BURWELL: What is our deadline,

3 Anne?

4 EXECUTIVE DIRECTOR SCHWARTZ: Well, that's

5 actually what I was just going to turn to. The request

6 actually doesn't have a deadline in it, but if the

7 territories' ability to use this money is going to run out

8 in this fiscal year, I think this needs to be in our June

9 report. I mean, there's value in continuing work in this

10 area, but certainly we should be talking about it for then.

11 And to that point, we have heard, not just from

12 you but from several other folks, that, you know, "Why are

13 you just doing Puerto Rico? You should do the other

14 territories too." And I think that's a fair point but I'm

15 also a little bit concerned because each territory is quite

16 different. I mean, Puerto Rico is clearly the biggest of

17 the territories. We're trying to get our arms around

18 understanding the situation in Puerto Rico. To the extent

19 that we'd have to try and do that for the other territories

20 too, it's a whole additional set of facts.

21 So I just want to temper the expectation that we

22 can do it all at once, but maybe think about how we can

1 take on some of those other issues in maybe a more modest
2 way.
3 I also just want to say that the national average
4 salary for a family physician is $219,000.
5 CHAIR THOMPSON: I think the June report that
6 we're talking about --
7 COMMISSIONER GORTON: I retired too soon.
8 CHAIR THOMPSON: -- in order to think about a
9 recommendation, set any recommendations. So let's just
10 walk back from that timing, because I'm also concerned
11 about that seems a long time to not say anything, so
12 apropos. So I'm just trying to think about, can we segment
13 this? Maybe there's an issue brief that we could issue,
14 with some of these things, in the next month or two, that
15 we could look at at the next meeting, with the idea that
16 then that gets expanded on, maybe with some recommendations
17 for June. You know, I don't want to like just hold it all
18 because we don't have it all.
19 EXECUTIVE DIRECTOR SCHWARTZ: No. I mean, we
20 have three meetings before the June report. We have
21 January, we have March, and we have April. We already have
22 an issue brief that contains much of the material that was

1 reflected in your background materials, at the last
2 meeting, that Kacey prepared, that -- I mean, I don't know
3 how out-of-date it is at this point, Kacey. You know
4 better than that. So it's not like we don't have anything
5 out there.
6 So, I think we need to think about what other
7 information we need to assemble and focus on to be able to
8 lead you to where you want to be.
9 I also just say, I mean, if you want to do
10 recommendations, you know, we're here to support you in
11 doing recommendations. I do think a report that sheds
12 light on things, as you said, Penny, is of value as well in
13 showing some of tradeoffs. So I don't think if you don't
14 do recommendations, if you can't find, you know --
15 CHAIR THOMPSON: Yeah. This is all the art of
16 the possible.
17 EXECUTIVE DIRECTOR SCHWARTZ: Right. I think
18 both of those have value.
19 CHAIR THOMPSON: So can we -- I mean, we don't
20 need to engineer it, and we're not going to engineer it
21 here. Can we just ask for you guys to go back? Let's at
22 least touch base on this subject at our January meeting,

1 and maybe, depending on how things -- how you think about
2 this conversation and digest it, there may be something
3 that we could expand on in terms of an issue brief. There
4 may be some things that we might want to particularly say
5 to the Congress in light of this request, about the status,
6 that could include some observations and some level of
7 concern that we might want to express. That's a
8 possibility.
9 So let's just think about it. I think, in the
10 end, what I would -- I mean, we're obviously aiming towards
11 a fairly major chapter in the June report, but I think we
12 really ought to be looking at opportunities ahead of that,
13 to make some kind of communication.
14 Okay. Any -- oh, Sheldon.
15 COMMISSIONER RETCHIN: Yeah, I just want to say I
16 know we've been at this before, on the territories, and
17 just to point out that Puerto Rico is 92 percent of the
18 population of the territories. So in any recommendation we
19 make it really is dominated by the Puerto Rican situation.
20 CHAIR THOMPSON: Thank you, Sheldon. Kacey,
21 again --
22 COMMISSIONER CARTER: Can I say something really

1 fast? When I talked about the quality measures I want to
2 make sure that I go on record saying that I wasn't actually
3 dinging the health centers at all for that, that a lot of
4 these measures have to do with access within the rest of
5 the health care system, or social determinants. So I
6 didn't want to be sounding like I was criticizing them for
7 this.
8 CHAIR THOMPSON: Thank you for that
9 clarification. I think we were all following you, though.
10 The challenges that they're facing are going to inevitably
11 have impacts on their results.
12 Okay. Kacey, thank you again. Great morning of
13 conversation on this subject, really much appreciated.
14 All right. So we have a slight challenge on the
15 schedule.
16 EXECUTIVE DIRECTOR SCHWARTZ: We will get there.
17 CHAIR THOMPSON: But we'll see what we can do.
18 So we're going to have a short presentation on MACStats,
19 the much beloved and looked-forward-to reference book, and
20 then we'll take a pulse on where we are on the program
21 integrity side.
22 [Pause.]

1 ### HIGHLIGHTS FROM THE 2018 EDITION OF MACSTATS

2 * MR. PARK: All right. I wasn't sure if you guys
3 were ready.
4 CHAIR THOMPSON: Oh, sorry.
5 MR. PARK: No problem.
6 CHAIR THOMPSON: Trying to figure out the next
7 session.
8 MR. PARK: Just quickly, we're going to present
9 some highlights today from our most recent edition of
10 MACStats, which was released last week. Much like the
11 actual production of MACStats, I'm going to let Madeline do
12 all the work, so that is it for me.
13 [Laughter.]
14 * MS. BRITVEC: Thank you, Chris. Glad to do all
15 the work again.
16 So MACStats is divided up into six sections --
17 five main sections, and then a technical guide. We're
18 going to go through just the key components of each section
19 today.
20 Section 1 goes into just the key statistics on
21 Medicaid and CHIP enrollment and spending.
22 Section 2 focuses more on the trends.

1 Section 3 elaborates on the state-level and
2 eligibility group as well as type of service and other
3 factors.
4 Section 4 goes into the eligibility
5 determinations, and Section 5 focuses on survey data.
6 The 2018 edition of MACStats includes 11
7 reprinted tables which show 2013 and 2014 enrollment and
8 spending data. These tables could not be updated due to
9 lack of available data caused from the transition from the
10 Medicaid Statistical Information System, or MSIS, to
11 Transformed MSIS, or T-MSIS.
12 All states have begun submitting T-MSIS data to
13 CMS, but these data are still being verified for
14 completeness and accuracy, so they are not yet ready for
15 publication. Once they are, we will update these tables on
16 our website.
17 Section 1 of this year's MACStats shows similar
18 trends to last year. Over a quarter of the country's
19 population was enrolled in Medicaid or CHIP for at least
20 some part of fiscal year 2017. Medicaid was 16 percent of
21 states' budgets in state fiscal year 2016, and Medicaid and
22 CHIP held a slightly lower share of the national health

1 expenditures than Medicare in 2016.

2 So now getting into the trends of the data, over
3 the last five years Medicaid and CHIP enrollment has
4 increased by over 27 percent. The bulk of this change
5 happened in the first initial years of the majority of the
6 ACA expansion. Since July 2015, Medicaid and CHIP
7 enrollment has had a steady increase at about 1 percent
8 each year; however, in the past year, from July 2017 to
9 July 2018, there has been a slight decline in enrollment.

10 Furthermore, this graph shows the trends and
11 growth rates. Spending and enrollment have had a
12 complementary growth trend, both rising and falling,
13 compared to policy changes and economic shifts. In recent
14 years, the growth rate for full-year enrollment and
15 spending both have declined, but they are still
16 experiencing a positive growth rate at about 2 percent
17 each.

18 Similarly, Medicaid and CHIP are both holding a
19 stable share of the federal outlays. In 2017, CHIP was 0.4
20 percent of total federal outlays, and this showed no
21 difference from the previous year. Exchange subsidies have
22 increased to 1 percent. Medicaid's share has decreased

1 slightly from 2016 to 9.4 percent, and it's still less than
2 Medicare's share, which is about 15 percent.
3 All right. Exhibit 13 compares Medicaid's share
4 of the state budget, so when we compare state funds, we can
5 see that both state general funds and all state funds
6 remained fairly stable and constant over the past four
7 years. However, when we add federal funds into the mix,
8 you can see that Medicaid's share of the state's budget
9 increases over recent years, and this is due to the
10 increase in FMAP for the new adult group post expansion.
11 Section 3 shows that the use of managed care
12 continues to increase. Capitation payments for managed
13 care were about half of all Medicaid benefit spending.
14 Over two-thirds of Medicaid enrollees are enrolled in
15 comprehensive managed care, and in fiscal year 2017, net
16 drug spending decreased slightly from the previous year.
17 Just as a note, Section 3 is where you can find
18 most of our republished MSIS tables.
19 As you will recall, last year we included a new
20 table, Exhibit 23, on the full-year equivalent newly
21 eligible adults and their spending compared to all full-
22 year equivalent enrollees. Like last year, spending for

1 full-year equivalent enrollee was less for newly eligible
2 adults than for all Medicaid enrollees. Spending per newly
3 eligible adult has decreased actually from the past fiscal
4 year, fiscal year 2016 to 2017, but spending per all
5 enrollee has grown modestly.
6 There were not any substantial eligibility
7 criteria changes in the past year. In 2017, 42 percent of
8 Medicaid enrollees had annual incomes less than $12,140 for
9 a single individual. Thirty-one states and D.C. are now
10 covering the new adult group. Four additional states have
11 approved Medicaid expansion but have not implemented it,
12 and that excludes Virginia, which has just started the
13 implementation process.
14 So Section 5 of MACStats reports survey data from
15 the National Health Interview Survey and the Medical
16 Expenditure Panel Survey. Results from this section were
17 very similar to last year's data. In 2017, those covered
18 by Medicaid or CHIP reported having a usual source of care
19 at a higher rate than those who are uninsured, but slightly
20 less than those who are privately insured, and Medicaid and
21 CHIP enrollees were more likely to have trouble finding a
22 doctor than those with private coverage.

1 That concludes our presentation.
2 CHAIR THOMPSON: As usual, again, I think people
3 really do look forward to getting the MACStats book, so
4 thank you for all of your work in compiling that. There
5 was a tremendous amount, we know, that goes on behind the
6 scenes to make sure that this comes together, so
7 congratulations again.
8 MS. BRITVEC: Not a problem. I hope you stuff
9 your stockings with it.
10 [Laughter.]
11 CHAIR THOMPSON: Questions from the Commissioners
12 on the results or the process?
13 [No response.]
14 CHAIR THOMPSON: All right. Thank you again.
15 Jessica, we're going to beg your pardon and ask
16 if you will come back and have this conversation on program
17 integrity at the next meeting. There is not an urgent time
18 frame for this, and I want to be sure that Jessica gets our
19 attention and we have ample time to discuss this and don't
20 want to just sort of rush this in at the end of the agenda
21 without having enough time for it. So we will just look
22 forward to that conversation next time then. Thank you.

1 Any last remarks or questions from the audience,
2 from the public?
3 **### PUBLIC COMMENT**
4 * [No response.]
5 CHAIR THOMPSON: Okay. We will bring our meeting
6 to a close. Thank you, Commissioners. Again, very
7 productive and good couple of days. Thank you.
8 * [Whereupon, at 11:33 a.m., the meeting was
9 adjourned.]
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