



PUBLIC MEETING

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

Thursday, October 25, 2018
9:32 a.m.

COMMISSIONERS PRESENT:

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CHRISTOPHER GORTON, MD, MHSA
CHARLES MILLIGAN, JD, MPH
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WILLIAM SCANLON, PhD
ALAN WEIL, JD, MPP
KATHY WENO, DDS, JD

ANNE L. SCHWARTZ, PhD, Executive Director

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CHAIR THOMPSON: Okay. Why don't we go ahead and get started.

Welcome, everyone, to our October meeting. We're going to kick off the day with a discussion of DSH, and our first session is going to be presenting updated analysis on the relationship between allotment and certain measures defined in the statute. And we have Rob and Madeline to walk us through this.

**### REQUIRED ANALYSES OF DISPROPORTIONATE SHARE
HOSPITAL (DSH) ALLOTMENTS**

* MR. NELB: Okay. Thanks, Penny. We have a double dose of DSH today, your favorite topic, and we're going to begin by reviewing some of the data that we are required to report annually.

I'm actually going to turn it over to my colleague, Madeline, who does the work in compiling all this data, and she's going to walk through all the different data elements we're required to pull, which are listed here. We're really going to focus on some new data that we have about amounts and sources of hospital

1 uncompensated care, using new data from 2014 DSH audits,
2 which finally start to give us some information about how
3 Medicaid shortfall has changed as a result of the ACA.

4 So I'll turn it over to Madeline and then I'll
5 talk about some next steps for pulling this together for
6 the March report.

7 * MS. BRITVEC: Okay. Great. Let's begin with the
8 number of uninsured. We gathered from the Current
9 Population Survey that 28.5 million people or 8.8 percent
10 of the U.S. population were uninsured in 2017, which showed
11 no statistical difference from 2016. About a quarter of
12 the uninsured individuals have incomes below 100 percent of
13 the federal poverty level and about half of them had
14 incomes under 200 percent of the federal poverty level.

15 From 2013 to 2014, the number of uninsured
16 decreased by 13.3 million, a 32 percent decrease, with
17 larger declines in Medicaid expansion states.

18 Secondly, we'll look at uncompensated care.
19 Throughout our research, we used three main data sources,
20 each with their own strengths and limitations. MACPAC used
21 the Medicare cost reports to access information on all
22 states and that defines uncompensated care as charity care

1 and bad debt. We used the Medicaid DSH audits to provide
2 accurate information on DSH, but the data is not timely.
3 We are presenting data from 2014.

4 DSH audits define uncompensated care as unpaid
5 cost of care to the uninsured and Medicaid shortfall, which
6 is the difference between Medicaid payments and the cost of
7 providing those services.

8 We used the AHA annual survey to compare our
9 findings on Medicaid uncompensated care, but it does not
10 provide state-by-state information, only national data.

11 Alright. There were slight changes in Medicare
12 cost report data from the previous year. According to the
13 Medicare cost reports, \$35 billion went towards
14 uncompensated care, and that is 3.6 percent of the nation's
15 total hospital operating expenses. And this \$35 billion is
16 an 8 percent decline from 2015.

17 About 60 percent of uncompensated care went
18 towards charity care and 40 percent went towards bad debt
19 expenses. States that expanded Medicaid under the ACA in
20 2016 experienced larger declines. And in past year we've
21 compared recent findings to the 2013 Medicare cost report
22 data. However, this year we are unable to do so due to

1 recent definitional changes in the Medicare cost report
2 instructions.

3 DSH audit data also shows change. To compare
4 years, we reviewed uncompensated care costs reported for
5 the subset of hospitals that were included in DSH audits
6 for both the state plan rate years 2013 and 2014, which was
7 92 percent of all hospitals in state plan rate year 2014.
8 The state plan rate year aligns with the state fiscal year
9 so that's about half a year of expansion.

10 And what we found was quite surprising. The
11 increase in Medicaid shortfall was larger than the decline
12 in unpaid costs of care to the uninsured between 2013 and
13 2014, so much so that the DSH uncompensated care increased
14 in both expansion and non-expansion states.

15 This figure shows uncompensated care for DSH
16 hospital by expansion status. As expected, DSH hospitals
17 in expansion states experienced a decrease in unpaid cost
18 of care for the uninsured, but what's unexpected is this
19 increase in Medicaid shortfall. Medicaid shortfall in non-
20 expansion states showed a similar trend, and overall the
21 reduction in unpaid cost of care for the uninsured is
22 outweighed by the increase in Medicaid shortfall.

1 So when compared with other sources, the decline
2 in unpaid cost of care to the uninsured makes sense.
3 However, the increase in Medicaid shortfall is a little bit
4 more difficult to explain. Medicaid cost reports show
5 hospitals reported a \$5.7 billion decrease in uncompensated
6 care between 2013 and 2014, and this is a lot larger than
7 what we found in our DSH audit data, the \$1.7 billion.
8 However, when considering that DSH audit data includes DSH
9 hospitals which are half of all hospitals, and accounts for
10 half of the year of expansion, this starts to make a little
11 bit more sense. The subset of DSH hospitals in our
12 analysis reported a \$3.5 billion decline in uncompensated
13 care on Medicare cost reports, which is about twice the
14 amount they reported for the first half of 2014 on DSH
15 audits.

16 The AHA annual survey reported a \$0.9 billion
17 increase in Medicaid shortfall between 2013 and 2014 for
18 all hospitals, which is much smaller than our DSH audit
19 findings. It's a little bit harder to explain, and yet we
20 will try.

21 To understand the change in Medicaid shortfall
22 more clearly we looked at the components of Medicaid

1 shortfall, and as a reminder, definitionally, Medicaid
2 shortfall is the difference between a hospital's cost of
3 providing services to Medicaid patients and the Medicaid
4 payments received for those services.

5 So Medicaid payments include base payments, which
6 are tied to services, and non-DSH supplemental payments,
7 which are not. Medicaid expansion states experienced a 10
8 percent increase in base payments, which makes sense due to
9 the increase in enrollment, and non-DSH supplemental
10 payments did not change.

11 Expansion states saw an increase in Medicaid
12 payments, but comparatively that percent change was lower
13 than the increase in Medicaid costs, showing that Medicaid
14 costs are more than Medicaid payments.

15 So in addition to the variation between Medicaid
16 expansion and non-expansion states there is also variation
17 amongst all states. This graphic shows Medicaid shortfall
18 as a share of uncompensated care costs for DSH hospitals.
19 Nationally, Medicaid shortfall was 33 percent of the total
20 DSH uncompensated care, with only a few states experiencing
21 shortfall having a share of over 75 percent. Fifteen
22 states did not report Medicaid shortfall and 14 states

1 reported shortfall that exceeds 50 percent of their total
2 DSH uncompensated care costs.

3 Lastly, we will turn to essential community
4 services. The term "essential community services" is not
5 defined with Medicaid's statute or regulation. MACPAC has
6 created a working definition based on suggested services
7 and statutory provision and the limitation of available
8 data. In our working definition we start by identifying a
9 deemed DSH hospital, which means a hospital that serves a
10 particularly high proportion of Medicaid or low-income
11 patients. These hospitals are required to receive DSH
12 payments, and in 2014 there were 832 deemed DSH hospitals.

13 Ninety-nine percent of those provided at least
14 one essential community service, 94 percent provided at
15 least two, and 83 percent provided at least three essential
16 community services.

17 MR. NELB: Thanks, Madeline. So as you can see
18 we got a lot of updated data, and our plan to pull this
19 together for the March report is to come back to you in
20 December with a full draft chapter that includes this data,
21 as well as some of the other contextual factors about DSH
22 that we normally provide, about the characteristics of DSH

1 hospitals. And then we plan to include that in the March
2 report.

3 I'm happy to answer any questions you have on
4 this session before we continue on round two of DSH.

5 CHAIR THOMPSON: Okay. We have Martha starting
6 us off.

7 COMMISSIONER CARTER: One thing that puzzles me
8 is the difference in how the DSH audits capture a certain
9 set of data and the Medicaid cost reports, and that's the
10 cost of care for people who are insured but have bad debt,
11 right? So is there any way to know that impact as we have
12 more availability of high-deductible plans and, you know,
13 now new on the market these short-term plans that are not
14 going to cover as much? Is there a way to sort of scope
15 out if that's part of, you know, the difference we're
16 seeing?

17 MR. NELB: Sure. So first just to clarify the
18 differences between the two sources. Medicare cost reports
19 include bad debt and charity care for people with insurance
20 as well as people without insurance. DSH audits mostly
21 include bad debt and charity care for people who are
22 uninsured. However, it also includes people who are

1 uninsured for a service, so if your plan didn't cover a
2 particular service, then even though you have insurance
3 you're still considered uninsured for that service.

4 COMMISSIONER CARTER: Well, if it covered the
5 service but you have a \$5,000, or whatever, \$10,000
6 deductible, where does that fall?

7 MR. NELB: Yeah. I want to double-check to make
8 sure I'm right on the specifics but there are some cases
9 where some of those patients may be included if they've
10 like reached a limit or something I think they may end up
11 being included in the DSH audit. So I'll double-check and
12 can get back to you on that.

13 So, yeah, there are some differences between
14 those and there is some data we can get to, to sort of
15 approximate some of the bad debt for people with insurance,
16 but we don't have full hospital-level data to use that to
17 fully explain the differences.

18 CHAIR THOMPSON: Okay. Stacey.

19 VICE CHAIR LAMPKIN: I have a couple of
20 questions. Thanks. This is really good stuff. My
21 questions also go to what the dollars on the various
22 reports represent. In either the Medicare cost report or

1 the DSH audit concept of uncompensated care, or unpaid cost
2 of care for uninsured individuals specifically, is there
3 any kind of income threshold at all, or you're uninsured,
4 you're uninsured no matter what your income is? That's my
5 first question.

6 MR. NELB: Yeah. There is no income threshold.

7 VICE CHAIR LAMPKIN: In either source.

8 MR. NELB: Correct. Often times for charity care
9 hospitals will have a charity care policy that does specify
10 a certain income for that, and so that may distinguish
11 whether they end up being treated as a charity care or bad
12 debt, but either way they're included, regardless of their
13 income.

14 VICE CHAIR LAMPKIN: So there could be some
15 inconsistency, hospital to hospital, in how dollars are
16 reported as bad debt versus charity care, based on the
17 hospital's own policy with respect to categorization.

18 MR. NELB: Correct, but under all circumstances
19 that patient would be considered uncompensated care under
20 both sources.

21 VICE CHAIR LAMPKIN: That's helpful.

22 My second question is, is there a Medicare

1 shortfall concept that's actually measured and considered
2 as part of Medicare DSH, or is that truly just a Medicaid
3 animal?

4 MR. NELB: So as if one DSH wasn't enough, so
5 Medicare also has a DSH program that uses the same acronym
6 but it's different rules. The policies for that are the
7 ACA sort of split that into two parts. One is an
8 uncompensated care fund, which is based on the charity care
9 and bad debt that's reported on the cost reports, so that's
10 for the uninsured.

11 There is a piece of Medicare DSH that continues,
12 which is sometimes considered to be the empirically
13 justified Medicare DSH. It in some ways is intended to pay
14 for Medicare shortfall, but the payments out of that are
15 based on sort of this historic formula that Medicare DSH
16 has used, which is actually based on the number of Medicaid
17 patients that a hospital has. But it's basically trying to
18 get at hospitals that maybe serve a lot of duals and also
19 disabled individuals, recognizing that they may just have
20 higher costs of care that maybe don't get recognized in the
21 Medicare payment formula. But it's a different concept of
22 shortfall than what we use in Medicaid for calculating

1 Medicaid shortfall.

2 CHAIR THOMPSON: It's almost like a proxy for
3 risk.

4 EXECUTIVE DIRECTOR SCHWARTZ: It's what is
5 considered to be Medicare's share of these other costs that
6 aren't covered, that is, Medicare will help kick in for
7 some of those and not relative to what Medicare paid
8 itself.

9 VICE CHAIR LAMPKIN: Yeah, that's really helpful,
10 I think, to understand, as we kind of also think about what
11 DSH might mean to Medicaid in the future, when we get to
12 the next section. But it sounds like you're saying that
13 there is some bifurcation of Medicare DSH, where there is a
14 portion of it that is strictly related to uncompensated
15 care for uninsured individuals -- for charity care,
16 basically, stuff.

17 MR. NELB: Yeah. So this was under the ACA,
18 Medicare DSH got reduced as well as Medicaid DSH, but the
19 way Medicare DSH was reduced was that the funds that were
20 going before, for Medicare DSH, kind of got divided into
21 two parts. One part continues at the old formula, which is
22 sort of based on this Medicaid and disabled patient volume.

1 The other portion goes to hospitals based on their
2 uncompensated care costs. And then the total amount of
3 funds in that sort of second pool is tied to the uninsured
4 rate nationally.

5 So, yeah, in some ways like Medicaid DSH pays for
6 both Medicaid shortfall and the uninsured. Medicare DSH,
7 you know, you can conceive of did both, but they sort of
8 bifurcated it and they now have different names, which we
9 can also get into in our report.

10 VICE CHAIR LAMPKIN: Thank you.

11 CHAIR THOMPSON: Okay. I'll come back to Martha
12 in just a second. Can I just ask about Medicaid shortfall?
13 So let's talk about that for a few minutes and what we make
14 of that. And my question is do we hypothesize that it's a
15 function of volume, which is the more Medicaid-covered
16 lives you have the more possible shortfall you come up
17 with. Do we hypothesize that it's a matter of rate-setting
18 for managed care, which is that we're seeing some maybe
19 inadequacies around rate-setting, or do we hypothesize that
20 it's about the cost of the expansion population being
21 greater, perhaps, than anticipated, or something else? And
22 do we have any way of parsing any of that?

1 MR. NELB: Sure. So I can take a stab. You
2 know, as Madeline said, we are sort of puzzling over this
3 data as well. So there is a piece that's due to costs,
4 right, because we saw that cost increased by more than
5 payments in both expansion and non-expansion states. But
6 costs are driven by a number of different factors and we
7 don't have the data to kind of get into exactly why the
8 costs are changing.

9 So in some cases the costs may increase because
10 of increased volume. They could also increase because of
11 the intensity or mix of services -- maybe these new
12 patients were more complicated to treat. It could also
13 increase just because of overall cost of the hospital and
14 just efficiencies in general. So there are different
15 drivers in there.

16 But I think we did see the cost piece is a key
17 part of that equation. And, you know, the payments
18 increased --

19 CHAIR THOMPSON: Can you just stop there?

20 MR. NELB: Yeah.

21 CHAIR THOMPSON: When you say now we saw that
22 costs were a key part, I mean, I don't know to separate

1 cost from the other things that we're talking about, right,
2 because it's all inputs to cost, as opposed to independent
3 elements about how the hospital operates or how it's
4 structure or how many employees it has, or those kinds of
5 things. So can you just say more when you say it seems
6 like it's more about costs, in terms of how you think about
7 that term, in light of what we --

8 MR. NELB: Sure. So I think costs, again, are a
9 factor that's driven by many different pieces of, you know,
10 utilization, mix of services, and just overall facility
11 costs. I guess, you know, we looked at what we saw in
12 between '13 and '14 and looked at how it compared to what
13 DSH hospitals reported between 2012 and 2013, and saw that,
14 I mean, that the payments increased more in '14 because of
15 increased coverage. So in some ways the payments have
16 improved but they haven't increased at the same rate that
17 the costs did.

18 So payments are still that other factor of the
19 equation, right, because shortfall is the difference
20 between cost and payments. Here I think we saw that
21 because payments are sort of divided between these base
22 payments and supplemental payments that the base payments

1 automatically increased sort of when you have more
2 utilization but the supplemental payments, at least for DSH
3 hospitals --

4 CHAIR THOMPSON: May not. May not.

5 MR. NELB: -- may not, yeah.

6 CHAIR THOMPSON: They could.

7 MR. NELB: They could, yeah, and vary by state.

8 So we're puzzling over it, for sure, but we take your
9 comments into consideration and we can think of how to
10 better articulate some of the different drivers, and even
11 if we don't know which one is the main one we can at least
12 say that these might be some of the big factors at play.

13 CHAIR THOMPSON: Okay. I have Martha, Fred,
14 Sheldon, Brian, Chuck, Kit, Bill. But Brian, are you
15 saying you want to jump in exactly on this point?

16 COMMISSIONER BURWELL: The non-DSH supplemental
17 payments are another driver in Medicaid shortfall, and in
18 Slide 11 it's clear that the non-expansion states have
19 lower base payments but higher non-supplemental payments.
20 So that's an interesting dynamic, in my view, so why the
21 shortfall is smaller in non-expansion states than in
22 expansion states.

1 CHAIR THOMPSON: Bill.

2 COMMISSIONER SCANLON: I was going to try and
3 abstain from commenting on Medicaid shortfall, having done
4 it in the past, but to the question you raised, Penny, I
5 think it would be useful to think about cost as driven by
6 units and cost per unit. And it's the units being affected
7 by the expansion and maybe changes in the population, and
8 the unit costs are being affected by what the hospital is
9 potentially doing with respect to how they're treating
10 people. And if we could have data to separate that, it
11 would be instructive.

12 CHAIR THOMPSON: Am I not right that there is
13 some information or suggestion that maybe the intensity of
14 care or the complexity of care needed by the expansion
15 population is greater than what people may have
16 anticipated? Or what do we know about that?

17 MR. NELB: Yeah, so we do know a little bit about
18 some of the mix of services for the expansion population
19 being a little different from the previous population, and
20 we're reviewing different literature reviews we're doing to
21 kind of compile that, and so we can take a look and then
22 match that with what we know about whether those services

1 are sort of more expensive or less expensive.

2 CHAIR THOMPSON: Because just to your point,
3 Bill, about, you know, the units times the cost and what's
4 in that cost, is it really just hospital driven, or is it
5 also population driven?

6 COMMISSIONER SCANLON: And you can define units
7 as either patients or adjusted patients, which would
8 reflect severity.

9 CHAIR THOMPSON: Yeah. Okay. Let's circle back.
10 So now we have Martha, Fred, Sheldon, Chuck, Kit.

11 COMMISSIONER CARTER: I think you're really --
12 you've already said to some extent what I wanted to try to
13 say, but I wanted to sort of put a primary care perspective
14 on this. You know, we really -- and coming from a state
15 that has a high percentage of Medicaid shortfall, we
16 certainly saw a lot of people who were not getting care
17 prior to expansion, and not just hospital care but
18 hospital-based testing, so preventive care --
19 colonoscopies, mammograms, things that would probably show
20 up in hospital rates, I assume, that weren't there before.
21 So I'm not sure how to try and regulate that, you know, how
22 to get to that information, but that's the experience on

1 the ground.

2 CHAIR THOMPSON: Fred

3 COMMISSIONER CERISE: I am thinking of the
4 shortfall question myself and trying to understand better.

5 Does the variation among states where you had so many
6 states report no shortfall and then it swings up to huge
7 shortfalls, do you have any sense for what's behind that?

8 MR. NELB: Sure. So one piece that's important
9 to know applicable to a state like Texas is that the
10 shortfall includes the base payments as well as the non-DSH
11 supplemental payments that they make. And so some states
12 sort of pay for shortfall by -- well, some of these states
13 have high base rates, and so, you know, that's one way to
14 do it. But there are also some states that are in that no-
15 shortfall category that have very high supplemental
16 payments. But whether it's UPL or a waiver payment they're
17 making for uncompensated care, they sort of pay for
18 shortfall a different way rather than using DSH payments to
19 pay for shortfall. So that's one piece, and we can look
20 more at particular states if you have questions.

21 CHAIR THOMPSON: I think that's an interesting
22 point, Fred, because maybe one of the ways to try to unpeel

1 the onion is to dive in on an individual state where we've
2 seen some of these changes and try to understand what
3 happened in that case, and maybe if we have a few of those,
4 we can see if we have, you know, complete variation on
5 what's happening at any given point in time because of the
6 connection of all these different factors that we're
7 talking about or whether we see some commonalities. That
8 might be a helpful way to understand what's going on.

9 Sheldon, Chuck, Kit.

10 COMMISSIONER RETCHIN: Let me start off with my
11 best Yogi Berra impression. I really do think this is so
12 complicated that if you've seen one state, you haven't seen
13 one state. But, nonetheless, there is so much variation
14 out there. I just want to point out that in terms of the
15 surprise element that Medicaid shortfall would outstrip the
16 reduction in uncompensated costs, I don't think there's any
17 surprise at that at all, and it was predicted by Kate
18 Neuhausen before the ACA was implemented. And that's
19 really because, prior to the ACA and the expansion, the DSH
20 payments to deemed DSH hospitals, particularly the large
21 ones, was based on -- it wasn't based on the market or
22 Medicaid policy. It was based on costs or some percent of

1 costs. Many hospitals, including the one I was at, were
2 getting in excess of 9 percent of costs. The Medicaid
3 substitution, we knew would drop us -- the shortfall would
4 way outstrip the advantage, quote-unquote, we would get
5 from the increase in the expansion.

6 The one last thing I guess I would say would be
7 that -- I've said this for many years, and it goes back 20
8 years when I visited the Medicaid program in Washington to
9 say that I still think that the DSH payments -- I know the
10 original reason for the DSH payments, but that the
11 concentration on hospitals in terms of payment I think is
12 misguided and leads to perverse incentives for hospital
13 behavior and hope that we would as a Commission come back
14 to review the California global payment mechanism. It may
15 be complicated, but I think it's the right thing to do.

16 CHAIR THOMPSON: Chuck and then Kit, and then
17 we'll wrap up this part of the conversation.

18 COMMISSIONER MILLIGAN: So just a couple of
19 questions. For the cost reports, are the hospital costs
20 audited or are they self-reported? So in terms of what
21 costs are reported in the cost reports, how much scrutiny
22 is given to those costs in terms of whether the hospital's

1 efficiently run? I'm curious about whether it's self-
2 reported or audited or how the cost reports are
3 constructed.

4 MR. NELB: So cost report data are not audited,
5 but the DSH audits are. I think they -- however, the cost
6 report data are used in different Medicare payment
7 calculations, and so there is some level of review for it.
8 I think it's less of a question about whether the
9 hospital's run efficiently, and it's more of a -- you know,
10 they just add up all the costs of the hospital in different
11 cost centers and then use that to sort of figure out the
12 costs that were spent on particular services. So it
13 doesn't give you a view whether those costs are too high or
14 too low, but, you know, it -- so, yeah, for better or
15 worse, though, cost reports are sort of routinely used,
16 even on the DSH audits, or just other ways for capturing
17 data on hospital costs. So it's not perfect, but it's sort
18 of the best approach that we have.

19 COMMISSIONER MILLIGAN: Part of the back to the
20 future that I'm experiencing is Boren Amendment. I'm
21 looking at Bill. You know, there's a notion when we talk
22 about shortfall that Medicaid ought to be paying costs, and

1 Medicaid stopped doing that in 1997 with the Balanced
2 Budget Act because it wasn't perceived to be a way of
3 driving incentives to be efficient. And at least at that
4 time, when Medicaid was obligated to pay hospital costs, at
5 least at that time it was audited costs so that you weren't
6 paying for things that were perceived to be excessive costs
7 or self-reported costs. So I just -- it is to me a weird
8 dichotomy between the fact that Medicaid long ago stopped
9 paying hospitals based on costs, but yet we still talk
10 about Medicaid shortfall being relative to costs.

11 CHAIR THOMPSON: Kit.

12 COMMISSIONER GORTON: Thank you. A brief
13 extension of Martha's comments from the perspective of a
14 health plan. Pretty common to see newly insured
15 populations consume services at higher rates because they
16 have this warehoused need. What I wanted to add to what
17 Martha said is you usually see that go away. You talked
18 about having six months' worth of '14 data. It may be
19 interesting to watch what happens as things play out and
20 not all the states rolled into the ACA at the same pace,
21 and so we'll have to be careful because they will see their
22 humps at different places. But pretty typically you see

1 this sort of six-month growth, and then as the populations
2 get under management, they come down to a more reasonable
3 level. So I would just keep your eye open for that.

4 Then the last piece I wanted to share,
5 Massachusetts has paid a great amount of attention over the
6 last few years about total cost of care, and I think people
7 know that, in fact, we have a legislatively mandated cap on
8 how fast total cost of care can grow. In the last couple
9 of years, the commercial and Medicare segments have stayed
10 within the cap. It was Medicaid unit cost pressure that
11 pushed it up, and you might chat with the people at the
12 Health Policy Commission to ask why they think that was the
13 case. That may give you other factors to include in your
14 noodling. But I think that Bill's point is spot on. You
15 have to think about unit cost and volume in two very
16 different ways. And as you think about unit cost, one of
17 the things to think about is the hospitals do experience
18 huge cost pressures because they have got to buy a lot of
19 stuff. They have to buy all these biologicals. They have
20 to buy all of this equipment. They have to buy all the
21 implantables and all of those other things. And to the
22 extent that we can illuminate a little bit what are the

1 factors that drive unit cost for the hospitals, which may
2 help us illuminate what are some of the other growth
3 drivers. You know, we've paid a lot of attention in the
4 Commission in terms of prescription drug costs. I think
5 that's true in biologicals. I think it affects hospital
6 costs. But I think medical devices, implantables, those
7 sorts of things are also other incredible, sort of under-
8 the-cover drivers of hospital costs.

9 CHAIR THOMPSON: Good. Great suggestions.

10 Okay. So we're going to now turn to the second
11 part of our double dip on DSH. Stacey is going to take the
12 gavel on this part of the conversation.

13 **### POLICY OPTIONS FOR STRUCTURING DSH ALLOTMENT**

14 **REDUCTIONS**

15 * MR. NELB: All right. Great. So we're back for
16 more. For our next DSH presentation, we're going to take a
17 closer look at DSH allotments themselves and some policy
18 options to better distribute reductions among states.

19 I'll begin by providing some background about
20 current DSH reductions and about why we began this work in
21 the first place to look at ways to better rebase allotments
22 based on factors of need. And then I'll review some of the

1 specific rebasing factors that we analyzed and how the
2 rebasing scenarios compare to policy goals that the
3 Commission has previously articulated.

4 Ultimately, I'll be asking for your feedback on
5 several decision points listed here. In particular, hoping
6 to get your feedback today and your thoughts on sort of
7 which measure would be best to use to rebase allotments.

8 Today is also the time to raise if there's any
9 other design features you think the Commission should
10 consider and particularly raise if you have any thoughts
11 about the assumptions that we made about how quickly
12 rebasing should be phased in and sort of how to phase in
13 between the current scenario and the rebased one.

14 Based on your feedback today, we plan to come
15 back to you in December with a full package of DSH
16 recommendations, and hopefully we'll have enough detail
17 that we may be able to get a score from the Congressional
18 Budget Office, and then our plan is to vote on
19 recommendations no later than the January meeting so that
20 it can be included in the March report. So lots of good
21 work ahead.

22 First, some background. DSH payments, as we just

1 talked about, are statutorily required payments that help
2 offset two types of uncompensated care: Medicaid shortfall
3 and unpaid costs of care for the uninsured. DSH payments
4 are limited by federal allotments, and these vary widely by
5 state based on state DSH spending in 1992 when DSH limits
6 were first established.

7 The ACA included reductions to DSH allotments
8 under the assumption that increased coverage from Medicaid
9 expansion and from health insurance exchanges would help to
10 reduce hospital uncompensated care costs. These reductions
11 were initially scheduled to take effect on 2014, but
12 they've been delayed several times.

13 Under current law, DSH allotments are scheduled
14 to be cut by \$4 billion in 2020 and \$8 billion a year in
15 2021 through 2025. This is more than half of states'
16 unreduced allotment amounts and is about 5 percent of total
17 Medicaid hospital spending.

18 Under current law, allotments are scheduled to
19 return to their higher unreduced amounts in fiscal years
20 2026 and subsequent years.

21 The statute specifies several factors that CMS is
22 required to consider to distribute DSH allotment reductions

1 among states. Most notably, CMS is required to apply
2 larger reductions to states with low uninsured rates and
3 larger reductions to states that do not target payments to
4 hospitals with high volumes of Medicaid patients or high
5 levels of uncompensated care.

6 Last year, CMS proposed a methodology based on
7 these factors. Specifically, CMS proposed distributing
8 about half of reductions based on the uninsured factor and
9 about half of reductions based on the targeting factors.
10 MACPAC commented on CMS' proposed methodology in August of
11 2017. However, because this was a proposed rule, our
12 comments were sort of limited to regulatory changes that
13 CMS could make. We didn't talk about any statutory changes
14 to the factors that are used.

15 The Commission has long held that DSH payments
16 should be better targeted to the states and hospitals that
17 need them most, and in our prior work, we found that,
18 unfortunately, the way that DSH reductions are currently
19 structured, they don't do very much to achieve these goals.
20 And so as a result, the formula preserves much of the
21 existing variation in DSH allotments and is unlikely to
22 improve the targeting of DSH payments to providers.

1 This may seem a little counterintuitive, but, you
2 know, it comes down again to how the allotments are
3 structured. So even those there is a factor in the
4 reduction methodology for the uninsured rate, the
5 methodology doesn't actually improve the relationship
6 between DSH allotments and the number of uninsured. And,
7 similarly, even though there are these factors related to
8 the targeting of DSH payments, it's unlikely that the way
9 that they're structured is actually going to change the way
10 that states target their DSH payments in the future.

11 And so as a result, when we talked in September
12 about a variety of different DSH recommendations that we
13 could make this year, most Commissioners seemed interested
14 in exploring a new way to structure DSH allotments rather
15 than making further tweaks to CMS' methodology. In
16 particular, Commissioners were interested in gradually
17 rebasing allotments based on measures other than historical
18 spending. This would require a statutory change, and so it
19 provides an opportunity for the Commission to think a
20 little more broadly than it did when commenting on the
21 proposed rule, so we can think of various changes to the
22 statute. However, for this exercise, we are assuming no

1 change in the total amount of reductions, so that the
2 Commission's recommendation doesn't increase federal
3 spending.

4 Because 2020 reductions are scheduled to take
5 effect in October of 2019, we set a goal of voting on
6 specific recommendations no later than the January meeting
7 so that they can be included in the Commission's March
8 report.

9 Okay. So to help kick off your discussion about
10 rebasing, we've analyzed the effects of rebasing allotments
11 based on three different factors that are related to the
12 number of people in a state likely to have uncompensated
13 care costs. We looked at using the number of uninsured
14 individuals in a state, the number of Medicaid enrollees
15 and uninsured individuals, and the number of non-elderly
16 low-income individuals in a state.

17 Here we defined low income as 200 percent of the
18 federal poverty level, which is the statutory definition of
19 low income used in the CHIP statute, and as Madeline
20 mentioned, about half of uninsured individuals have incomes
21 below 200 percent of poverty, and 200 percent of the
22 federal poverty level is about \$50,000 for a family of

1 four.

2 We considered basing allotments based on the
3 amount of uncompensated care in a state, but as we
4 discussed earlier, the available data have several
5 limitations. So we could use Medicare cost report data,
6 but it defines uncompensated care differently than the
7 definition used for DSH, and those data aren't audited.
8 And then we could use DSH audit data, which, you know, do
9 use the DSH definitions but they are lagged, and they're
10 only limited to DSH hospitals.

11 So in order to estimate the effects of some of
12 these different scenarios that we're interested in, we had
13 to make several assumptions about how rebasing might work
14 in practice. These assumptions are really for illustrative
15 purposes, and so if you have thoughts on other ways, other
16 assumptions we should make, you know, let me know.

17 First, because hospital costs are affected by the
18 cost of care in different geographic areas, we adjusted all
19 the rebasing factors based on the Medicare Wage Index to
20 account for different labor costs in different areas. And,
21 second, we assumed that rebasing would be phased in
22 gradually, and this was really to minimize the reductions

1 for states that have allotments that are much higher than
2 their rebased amount.

3 Your materials go into all the different
4 assumptions that we made. I just want to highlight four
5 for you here.

6 First, we assumed that DSH reductions would be
7 extended throughout the entire CBO budget window, which
8 would provide savings that could be used to phase in DSH
9 reductions over four years rather than two.

10 Second, we assumed that DSH reductions would be
11 applied to unspent DSH funding first to minimize reductions
12 to states that are currently spending their full allotment.

13 Third, we assumed that there would be -- when
14 you're doing the rebasing, we assumed that there would be
15 sort of smaller increases to states with allotments below
16 the rebased amount to sort of phase that in a little more
17 gradually.

18 And, finally, we set an upper bound on state DSH
19 reductions at 30 percent a year in order to just minimize
20 disruption for those states that have allotments that are
21 much higher than the rebased amount.

22 This figure illustrates the four-year phase-in of

1 DSH reductions that we're assuming. As you can see, under
2 current law DSH allotments go until 2025. We're proposing
3 to extend that until 2028. CBO estimates that doing so
4 would result in about \$6.3 billion in federal savings, and
5 so we think that this could be used to phase in reductions
6 over four years rather than two. Of course, the full
7 effect of any proposal will be contingent on all the other
8 pieces of our recommendation.

9 Okay. So with that background, let's talk about
10 how these different scenarios compare to various policy
11 goals that the Commission has articulated.

12 First, we examined the extent to which rebased
13 allotments improved the relationship between DSH allotments
14 and measures related to hospital uncompensated care costs.

15 Second, we looked at the extent to which how
16 reductions affected expansion and non-expansion states
17 since at the September meeting some Commissioners suggested
18 that reductions should be applied to states independent of
19 their state coverage choices.

20 And, finally, because we know that DSH funding is
21 an important source of revenue for many hospitals, we
22 looked at the extent to which the policies phased in

1 changes in an orderly way in order to minimize disruption
2 for those hospitals.

3 So this figure shows DSH allotments per uninsured
4 individual relative to the national average, and you can
5 see that the rebasing scenario helps improve the variation
6 between DSH allotments and the number of uninsured
7 individuals in a state. This is showing what it would look
8 like by 2023, about four years into the rebasing. So under
9 the status quo, only five states would have DSH allotments
10 per uninsured individual within 10 percent of the national
11 average, but under the rebased scenario, more than half of
12 states would have allotments within that range by then.
13 And we found similar results for the other rebasing
14 factors, which makes sense, because one of the goals of
15 rebasing is to improve the relationship between allotments
16 and the rebasing factors.

17 So knowing that the rebasing scenarios are better
18 than the status quo, the question then becomes which
19 measure should be used to rebase allotments. And to answer
20 this question, you may want to consider how the various
21 rebasing measures compare to hospital uncompensated care
22 costs.

1 So when we looked at uncompensated care costs
2 reported on both Medicare cost reports and on DSH audits,
3 we found that the number of uninsured individuals was most
4 closely correlated with levels of uncompensated care in the
5 state. Conversely, the measure of the number of Medicaid
6 enrollees and uninsured individuals was least correlated
7 with levels of uncompensated care.

8 However, it's important to note that no measure
9 we looked at was perfectly correlated with the hospital
10 uncompensated care costs, even after we did that wage
11 adjustment. And so under any rebasing scenario, there will
12 continue to be some variation between DSH allotments and
13 total amount of uncompensated care in the state even after
14 allotments are fully rebased.

15 So this table shows the effects of different
16 rebasing scenarios on states that expanded Medicaid and
17 those that did not.

18 Under all scenarios, the amount of reductions is
19 the same, 57 percent reduction, but you can see that under
20 the scenario of rebasing based on the number of uninsured
21 individuals, it results in larger reductions for states
22 that expanded Medicaid.

1 Conversely, if reductions are based on the number
2 of Medicaid and uninsured individuals in a state, it would
3 result in larger reductions for states that did not expand
4 Medicaid.

5 Rebasing allotments based on the number of low-
6 income individuals in a state results in a policy that is
7 sort of in between those two alternatives.

8 Under all the rebasing scenarios, most states
9 would have allotments that are within 10 percent of their
10 rebased amount within 5 years based on the assumptions that
11 we put in place. However, some states would still have
12 allotments below the rebased amount after 10 years, again,
13 because we assumed that the increases would be applied more
14 gradually than the decreases.

15 The pace of rebasing that we observe is really a
16 result of the different assumptions that go into our
17 analysis, and so, if you'd like, we could make different
18 assumptions to phase in rebasing more quickly or more
19 slowly. However, I just want to point out that because the
20 total amount of DSH funding is fixed, any policy that
21 reduces DSH cuts for some states would result in larger
22 cuts for other states. So there's definitely some

1 tradeoffs to consider.

2 Your materials include more information about the
3 state and provider effects of each rebasing scenario.

4 Again, although the total amount of reductions is the same
5 under all scenarios, there are going to be different
6 winners and losers among states, depending on which factors
7 is used.

8 However, I do want to point out that there are
9 two different ways that some states may be able to
10 potentially minimize the effects of DSH reductions on
11 providers in their states. First, some states may choose
12 to pay for Medicaid shortfall by increasing other Medicaid
13 payments outside of DSH, such as base payments or non-DISH
14 supplemental payments. And, second, some states may choose
15 to minimize the effects of DSH cuts in particular hospitals
16 by targeting the remaining funds towards those hospitals.

17 In order to examine these different scenarios, we
18 have provided some of the state-by-state data looking at
19 what payments to providers would be if states did pay for
20 Medicaid shortfall through regular Medicaid payment rates,
21 and we also looked at the extent to which the reduced DSH
22 allotments would be sufficient for states to make the same

1 amount of payments that they're making now to deemed DSH
2 hospitals, which is that group that's required to receive
3 DSH payments and serves a high share of Medicaid and low-
4 income patients.

5 I won't get into the specifics of the state and
6 provider effects now, but if you have questions, I'm happy
7 to answer them.

8 So that concludes my presentation for today.
9 I'll leave you with these three decision points that I
10 mentioned at the beginning, but again, I look forward to
11 your feedback so we can come back to you with a full
12 package in December and make progress towards a
13 recommendation in January.

14 Thanks.

15 VICE CHAIR LAMPKIN: Thanks, Rob. That was
16 really great. It really moves us forward from our
17 discussion at the last meeting.

18 Before we dive into our detailed discussion, I
19 just want to remind us that this is just one piece of our
20 DSH discussion. We have talked in the past about different
21 approaches that states use to allocate the DSH dollars
22 amongst hospitals within the states. We've also talked

1 about the connections of the DSH funding stream to other
2 ways that Medicaid pays hospitals.

3 We are not done with DSH after the next couple of
4 meetings because we are going to have some of these other
5 questions that we will need to come back to, but the timing
6 right now is such -- and we talked about this last meeting
7 -- that we have an opportunity to really now, as we move
8 into what looks like the reductions taking effect, try to
9 provide some guidances about rationalizing the distribution
10 across states, which are heavily, heavily influenced by
11 this, the historical spending anomalies of the past and not
12 really connected to the measures that they should be
13 connected to. So just setting that stage, there are
14 definitely other parts of DSH we'll be coming back to.

15 Then as we dive in, Rob has given us quite the
16 task list here, and I would like to suggest that the
17 measures that he's presented us with have some implicit
18 connections to the goals and the tradeoffs between
19 different goals. That may be useful for us to articulate
20 that a little bit, see how much consensus we have around
21 what we think the uncompensated care that we're most
22 interested in targeting is, and that may give us some

1 direction or some ideas about the appropriate measure or
2 measures or different additional information that we need,
3 if we can even just narrow down the measures.

4 So is there anybody who would like to start off?

5 Fred, do you want to start us?

6 COMMISSIONER CERISE: Sure.

7 First, Rob, great work, as usual. You have
8 really laid out, I think, a real thoughtful analysis and
9 given us some good direction.

10 Just to weigh in on a couple of your earlier
11 questions, the phase-in to 2028, I think that's a good
12 idea, sort of gradually get into it. Using unspent DSH
13 dollars first, I think is a good idea of setting some
14 guardrails, so there's no wide shifts. I think the way
15 you've outlined that makes a lot of sense.

16 To your three sort of scenarios, it sounded like
17 basing it on the number of uninsured is the one that most
18 closely reflected the uncompensated care by states.

19 The other thought I have about that option -- and
20 you can correct me if this is not accurate, but states have
21 a number of vehicles to address Medicaid shortfall with
22 supplemental payments, so starting with base rates, and

1 then if you don't want to do it in base rates and if you
2 want to rely on supplementals because you got flexibility
3 and non-state match, you've got other options there. But
4 you have fewer options when it comes to the uninsured side
5 of the equation.

6 So if the concern is the shift in Medicaid
7 shortfalls, states have a way to address that, whereas they
8 don't have the same flexibility to address the uninsured
9 problem which for me would be a reason to focus it more
10 heavily on the uninsured rate, even though, admittedly,
11 states do have a way to address that too by doing Medicaid
12 expansion. But if we take the premise we're not going to
13 do an expansion, non-expansion, go to that issue, and you
14 just base it on the problem to be solved. Basing it on
15 uninsured would seem to be the more even way to address the
16 problem across states, getting away from history.

17 VICE CHAIR LAMPKIN: Thanks.

18 Bill and then Sheldon.

19 COMMISSIONER SCANLON: First, I'd go back to the
20 earlier discussion we had about cost and the difference
21 between volume and unit cost.

22 I am really glad that you made the adjustment for

1 the cost, the Medicare cost index. I think that should be
2 a very prominent part of any recommendation because we have
3 got so much in terms of federal law, which uses one number
4 nationally, a poverty number, and for all kinds of
5 different programs. The reality is that both for
6 individuals and their incomes, there's big differences in
7 cost of living, and so your circumstances, where you are in
8 life relative to where you are with respect to the National
9 Poverty Index is potentially very different.

10 And the same thing is true with respect to the
11 delivery of care. Variation in cost is very significant,
12 and we have a very convenient, thanks to Medicare, measure
13 to use to try and sort of make the adjustment. So I really
14 think we should stress that.

15 In terms of the measure that should be used, I
16 feel like if you introduce Medicaid, you're trying to serve
17 the dual purpose of both adjust for uncompensated care and
18 adjust for the shortfall, and you know I have had concerns
19 about the shortfall.

20 But at the same time, we're in a very interesting
21 period here, which is not introducing Medicaid creates an
22 incentive against expansion. I understand we're phasing

1 this in, but if you want to neutralize, make the incentives
2 the same, I think you think about introducing Medicaid as a
3 measure.

4 But I'm not sure you should weight the two the
5 same, count each Medicaid-eligible and each uninsured,
6 because the consequences in terms of the cost of delivering
7 them services are different. So we might think about how
8 do you weight it for how much of an issue it is for a
9 hospital to have a Medicaid patient and the shortfall
10 associated with it and hope we could measure a shortfall
11 better and then what are the consequences for the hospital
12 having sort of an uninsured patient.

13 The last thing about the measures, I saw you
14 adjusted in the last one for the non-elderly and only
15 talked about non-elderly low-income people. I think the
16 same should be applied if you introduce Medicaid. If we're
17 talking about Medicaid seniors -- I mean, essentially, it's
18 for duals. That where Medicare is going to be the hospital
19 payer and they should not be counted in this.

20 I understand the arguments -- and we may hear
21 some of them -- about the issue should DSH be targeted only
22 on hospital services. That's a different discussion we

1 could have.

2 CHAIR THOMPSON: Sheldon, then Penny.

3 COMMISSIONER RETCHIN: First, I'll ask a question
4 and then come back to the issue I have regarding third-
5 party involvement.

6 Rob, I personally advocate your approach on low-
7 income individuals. I think it tracks kind of in principle
8 the way we look at FMAP and the allocation of Medicaid and
9 federal share. So that's attractive to me.

10 But could you take a state? And let me just
11 offer Virginia. Many of the changes that the different
12 allocation methods don't really make that much of a
13 difference, and overall, it is very slight, remarkably
14 slight. But then I look at a state, and maybe it just has
15 to do with expansion and non-expansion. In Virginia, can
16 you tell why does that make such a big difference?

17 MR. NELB: Let's see. Sure. In your materials,
18 we have two different ways we looked at the state effects.
19 One was the change in allotments, and another was sort of
20 estimated change in DSH payments.

21 COMMISSIONER RETCHIN: Just do allotments.

22 MR. NELB: Got it. Yeah.

1 This includes both spent and unspent allotments,
2 and so Virginia seems to be a case where they maybe don't
3 spend their full allotments. What maybe looks like a big
4 cut, when you're just looking at the allotments, may not be
5 quite as big of a cut when you're looking at the amount
6 that's spent on providers.

7 To get into a particular state, I'd have to
8 double-check the different numbers. Of course, we used
9 factors from 2016, and so Virginia is a new expansion
10 state. Number of uninsured will change in the future and
11 different things, so this is looking at sort of their pre-
12 expansion state, where they were.

13 Yeah, it looks like they -- well, the status quo
14 scenario is sort of its own piece, but as a non-expansion
15 state, they had sort of more uninsured than average. So
16 they were going to get an increase --

17 COMMISSIONER RETCHIN: Yeah.

18 MR. NELB: -- under our rebasing scenario, but
19 when you counted Medicaid and uninsured as a non-expansion
20 state, they got a decrease there. Under the low-income
21 scenario, they were pretty much stable.

22 COMMISSIONER RETCHIN: So maybe in December, I'll

1 take back what I said and that maybe understanding a state
2 or two would be useful, especially in the wide
3 fluctuations.

4 Then just to make a point now in session, I've
5 said this before. I do think I understand we can't solve
6 DSH entirely, I guess, in perpetuity, but I still think
7 that having third parties in states responsible for
8 allocating supplemental payments doesn't -- it's linked
9 back to the notion of provider taxes, which I as an
10 individual was able to determine where my taxes go. I
11 think that in terms of provider taxes, it doesn't, in
12 principle, make sense to me.

13 VICE CHAIR LAMPKIN: Thanks, Sheldon.

14 Penny, then Alan.

15 CHAIR THOMPSON: So I had sort of similar
16 sentiments I think to Sheldon.

17 I was a little struck by some of the state-by-
18 state. When we look at the total universe and kind of
19 where people are gravitating to, that's kind of one, an
20 important element of analysis. The state-by-state numbers
21 look quite striking in some cases.

22 What are your thoughts about how to -- is it

1 because of this -- like we need to dig in a little bit
2 better and see where the state-by-state effects are, or is
3 there a way to soften those effects so that they're not so
4 dramatic? Can you just speak to if there needs to be an
5 adjustment or there needs to be a recognition of other
6 things in particular states?

7 MR. NELB: Sure. So there's two different
8 differences, I think you see. One is the variation between
9 the different factors, which it's like a non-expansion
10 state will maybe do better under the uninsured and an
11 expansion state will do better under the other factor.

12 The other piece, though, is where you see sort of
13 big cuts for a state, even regardless of the scenarios, and
14 this comes down to a state that spent a lot of DSH funds in
15 1992 and is sort of -- compared to other states is sort of
16 much higher relative to any sort of average.

17 And to soften the effects on those states, you
18 basically want to slow the pace of rebasing, and it could
19 be done in a couple different ways. As it is now, we
20 assume that the increases for the low-DSH states are
21 happening at the same time as the decreases. You could
22 kind of push off some of the increases for low-DSH states.

1 You could look at that upper bound on cuts. We assume that
2 30 percent, you could have a smaller amount. So we can
3 look at some different ways and perhaps come back to you
4 with a closer look at these are the states that are going
5 to be most affected and maybe looking at whether we think
6 they would potentially be able to offset the cuts by
7 increasing other payments or whether they wouldn't. So we
8 can take a look.

9 But, basically, those states with the really big
10 cuts are ones that -- I mean, also even tend to get big
11 cuts under the current methodology, but just because their
12 allotments are so large. Yeah, that's correct.

13 CHAIR THOMPSON: I think that would be helpful.

14 And then the other thing that I would say is that
15 I'm probably more in Sheldon's camp about which measure.
16 I'd like it because it's neutral. I do understand the
17 point of -- I've been concerned about Medicaid shortfall
18 and about creating the wrong incentives. I do agree that
19 states have levers for that, but also states have levers
20 around coverage decisions.

21 I think when we focus only on the uninsured, I
22 think by distributing reductions that were thought of as

1 applying across all states now to primarily affect states
2 that made expansions, I think we kind of have the opposite
3 effect of too much happening in expansion states versus
4 non-expansion states.

5 I think low income is a good proxy, especially at
6 the state level for DSH distribution. I think when we get
7 into some of the other conversations that we might want to
8 have later about how this relates to non-DSH supplementals,
9 how this relates to distributions within the states, I
10 think there's opportunities then to use some different
11 levers to have some different kinds of conversation.

12 When we talk about rebasing across the states, I
13 think looking at low income as a proxy for need and
14 pressure on the state around its safety net system seems a
15 reasonable place to go. The fact that it happens to have
16 kind of middling effects in comparison to the other two
17 options applies to my centrist, you know, inclinations, but
18 it's more about taking it off of the plate of state options
19 and decisions and going to something about the populations
20 that are needing to be served.

21 VICE CHAIR LAMPKIN: Alan and then me.

22 [Laughter.]

1 COMMISSIONER WEIL: I'm going to end up pretty
2 much where Penny did, so I'll try not to be repetitive.

3 It is striking to me, as important as this set of
4 decisions is, that when you present to us the tally of the
5 number of states affected in certain ways by the different
6 policies, they are strikingly similar over at the
7 aggregate. So I'm sitting here thinking we are looking at
8 these very different choices, and we have to get it right.
9 And we do.

10 But it's less calibrated than I had thought at
11 the outset. I think this notion of looking at it sort of
12 at the state level and realizing that whatever differences
13 there are in these approaches, they're actually quite
14 consistent in the number of states they affect in the size
15 of their cuts overall is telling to me that we shouldn't
16 try to over-engineer this.

17 I'm drawn to -- Stacey, I liked your trying to
18 keep us to the goals at the beginning, and what I'm
19 realizing in my own thinking and in my listening to my
20 colleagues here is that the goal that we've stated of
21 applying reductions to states, independent of state
22 coverage choices, is not a simple goal to interpret because

1 there's the question of are you penalizing or not for a
2 decision one way or another, or what are the incentives for
3 making the decision. Are you changing the incentives for
4 deciding one thing based on -- and so this, I think, is
5 actually the crux of the matter, is that as much as it
6 sounds good to say, "Oh, we don't want to get in the middle
7 of," by definition, we are in the middle of. And there is
8 no way for this choice to be completely independent of
9 state and coverage goals.

10 So that's where I land, and I'll just say it
11 slightly differently than Penny. But I think it will
12 hopefully sound fairly similar.

13 We've talked a lot over the years about how many
14 different lever states have on payment. So you have to
15 look at this in the context of those other levers.

16 What is it that's unique about DSH? Two things.
17 One is it, by federal design, is designed to support
18 hospitals that have a disproportionate share of needy
19 populations. So that makes it relevant but targeted.

20 But the other is it's now capped, and most of the
21 other levers we talk about are not capped. Your payment
22 rates, you can change your payment rate. There's no cap.

1 So I go to the notion that within state -- and I
2 don't want to lose Sheldon's point. Within state, I think
3 it's very important how the allocations are made within
4 state, and maybe at some point, we're ready to take that.
5 But before we take that on, across states this really
6 should be tied to, if you will, a more objective standard
7 of underlying need, not so much tied to the other policies.

8 From work I've done elsewhere, low income has
9 some of the same cost adjustment problems. Below 100
10 percent of poverty is a very different share of people in
11 New England, in Massachusetts, than it is in Alabama, but
12 still moving more toward an income-based or poverty -- a
13 number base that's consistent with how FMAP is calculated,
14 and it avoids stepping on and changing the policy
15 incentives associated with coverage or other payment rates.
16 So that's where I would tend to go.

17 VICE CHAIR LAMPKIN: Thanks. I'm going to weigh
18 in and then it'll be Darin, Kit, Martha, and I wanted to go
19 back to the goals, too, and talk about that, because I
20 agree with Alan. I think it's really tough to stay out of
21 the coverage decision here in this dynamic.

22 I personally am more aligned with Fred's

1 preference, and the reason -- maybe I'm bringing different
2 goals in than are on our slide, but for me the concept of
3 transparency and rationality are coming into play here.
4 And yes, I'm thinking ahead to kind of our other payment
5 streams conversations. But it's strongly appealing to me
6 to say we want to be able to know what we pay for Medicaid
7 services, to Medicaid individuals, and the more places that
8 you have to go to find those dollars and try to pull them
9 into some kind of rational measure makes things really
10 challenging.

11 Plus Fred's comment that states have other levers
12 that they can use to rationalize or to make appropriate
13 payment for Medicaid services leads me to favor the low-
14 income -- I'm sorry -- the uninsured measure, with the low-
15 income one being my second choice. I do understand the
16 arguments for that, but I just really -- it appeals to me
17 to think that uncompensated care here could focus not only
18 Medicaid shortfall it's cleaner to have that dealt with
19 somewhere else. So that's my own thought.

20 All right, Darin.

21 COMMISSIONER GORDON: Well, so I'm glad you went
22 before me, because I think that was a good articulation of

1 where I'm at. I think the points that Fred made are good
2 ones. I do think, to some degree -- and when we talk about
3 some of the state variations too, we're also hindered by,
4 you know, some of this is an artifact of the old model and
5 so some of these changes are almost -- well, let me say it
6 this way. We can't act as if that was the perfect state to
7 begin with. And so some of those dynamics, we're going to
8 see some big swings regardless because things are very
9 different.

10 But for all the reasons Fred had stated, and
11 Stacey, I'm more aligned in prioritizing uninsured. I do
12 think, to some degree, you know, we don't have to
13 necessarily say, when you think about the uninsured or if
14 you think about Medicaid shortfall that it's an equal
15 weighting on both. I mean, that's another option is to
16 weight those differently. But I lean more on the uninsured
17 side, thinking that that is the bolus of where I've seen
18 DSH funding go in the past. It is a dynamic that doesn't
19 go away, whether you expand it or you didn't. It's
20 something that's going to have to be addressed. And then
21 we can get into all sorts of other discussions, to
22 Sheldon's point, about how, if you look at those formulas

1 within states and how those things are administered and
2 driven that there's a whole other discussion there.

3 VICE CHAIR LAMPKIN: Thank you. Kit, then
4 Martha, Toby, and Melanie.

5 COMMISSIONER GORTON: So first thank you, Rob,
6 for once again -- and Madeline and everybody else -- for
7 taking enormously complex stuff and making it somewhat
8 understandable, even for simple-minded people like me.

9 One, so I would agree with what other people have
10 said, either the uninsured one or the low-income one, and
11 for me I'm not sure there's a clear first choice. I can
12 make either argument. So whatever the sense of the
13 Commission would be I think I would be comfortable with
14 that. I do think that taking Medicaid shortfall out of it
15 makes sense, for all the reasons that have been articulated
16 and I won't repeat them here.

17 What I wanted to do was ask you, Rob, and Anne,
18 maybe, to remind us, inform us, educate us, when we deliver
19 this chapter how will the staff capture this sort of --
20 which have infinite possibilities, and then we're down at
21 three options, and we ended up in this place, or do we just
22 simply say -- and I apologize, I don't remember -- we think

1 you should do this?

2 So it would be helpful to me to understand how
3 much of the background thinking about the choices we made,
4 the options we considered, and where we finally landed,
5 will we be sharing that with Congress and with the
6 audiences so that if they decide they don't like our
7 recommendation they at least have the benefit of the
8 discussion.

9 EXECUTIVE DIRECTOR SCHWARTZ: Typically what we
10 would do is there's a recommendation, which, as you've
11 heard me say a number of times, is a specific thing that
12 we're recommending a specific somebody do. In this case it
13 would be a change in the statute; Congress change the
14 statute to X. And then in the rationale you would say why
15 we came to this decision and what other alternatives we
16 considered and why we thought the one we chose was
17 superior, for whatever reasons. And you can also say, in
18 that part, that none of them is perfect. You can structure
19 that rationale to help the decision-makers understand why
20 you made the decision and what else we considered.

21 Also, just to remind you that the decision-makers
22 are privy to all of this as we go along, in any case, and

1 how that factors into their ultimate decisions to do
2 whatever is beyond our control.

3 VICE CHAIR LAMPKIN: Okay. Martha, then Toby,
4 and Melanie.

5 COMMISSIONER CARTER: I'm going to go back to the
6 point I made earlier, my worry about individuals who are
7 insured but have high deductibles or somehow are going to
8 wind up bad debt. I wish I had a crystal ball to see how
9 all the changes are going to affect us. And, you know,
10 we're handicapped working with old data. But at the
11 primary care level we're certainly seeing an increase in
12 bad debt, somewhat because of employer choices in the
13 coverage plans that they can afford. So we've got people
14 with high deductibles that wind up receiving care but then
15 not being able to pay their bills.

16 And then with the approval of plans that don't
17 conform to the ACA coverage requirements we're going to
18 wind up with people who are insured but not covered in the
19 same way that they have been, perhaps, in the past, coupled
20 with, perhaps, people coming off Medicaid in states that
21 implement work requirements. And so we've got this whole
22 constellation of changes that could be coming that could --

1 and I think we're already seeing it at the primary care
2 level, to some extent -- that could increase the bad debt
3 rate for people who are insured but can't pay their bills.

4 So for that reason I'm just expressing the worry,
5 I want to get it out there -- I'm a worrier -- but also I
6 think that makes me come down on the option of low-income
7 rather than tying it to a payment methodology.

8 VICE CHAIR LAMPKIN: Toby.

9 COMMISSIONER DOUGLAS: So I also recommend the
10 methodology of low-income, and I start from aligning with
11 the comments that others made on that definition but also
12 the fundamental for me is that this is about one payment
13 stream of many. So as we think through the structure, the
14 allotments, it's really on a definition that doesn't get
15 into policy choices around Medicaid expansion or not,
16 because states that expanded weren't really thinking about
17 -- they made their expansion decision putting aside
18 payments in another lever. And so there's the allotments.

19 Then there's how states use it, and that gets
20 into the definitional and the transparency of whether
21 they're using it to cover uninsured, uncompensated. So
22 really separating those two pieces but focusing on

1 allocations here, and then there gets to all the issues
2 about how states structure and what's our definitions,
3 given states use it differently now.

4 VICE CHAIR LAMPKIN: Melanie.

5 COMMISSIONER BELLA: Yeah. Thanks, Rob. A
6 couple of comments and one question. So comment, just
7 going to the timing. I just want to say I agree with Fred,
8 which is in support of your recommendation of carrying it
9 out to 2028, just because we haven't talked about that.

10 Second is I'd reiterate, I guess, what Toby and
11 others have said. I, too, come down on the low-income
12 individuals. As Sheldon and Penny have both said, I mean,
13 it is very much in line with how we think about FMAP and I
14 also like the fact that it's more balanced. And I guess I
15 would say like put aside for expansion for a minute. There
16 are other policy things we'll be talking about today, like
17 work requirements, that will influence uninsured rates, and
18 I think we just have to think about, we really don't want
19 to have anything in this program that is incented or not,
20 unintentionally. And so there are different things that
21 can drive that in ways that low-income individuals cannot.

22 And so I guess my question is a couple of times

1 there was the reference to states have tools, and it was
2 part of the rationale, I think, for supporting the number
3 of uninsured. I don't understand what that is. If the
4 tool is that the state can increase the base rate, I don't
5 think we can rely on those kinds of tools. States don't
6 have a lot of extra cash sitting around to increase the
7 rates.

8 And so I'm just curious, what are the extra
9 tools, either Fred or Dan, you were referring to?

10 COMMISSIONER GORDON: So, I mean, presumably, in
11 some cases, I mean, granted, in some cases, DSH is
12 supported by hospital taxes, but otherwise they are
13 supported by general funding. And so if there is a
14 reduction in your DSH portion of share payments that's one
15 avenue which, if you were to deploy that funding, if you
16 put it into your base rates you would still get the same
17 match and be able to do it. And back to Stacey's point,
18 which I really do like, gives a little bit more
19 transparency to really what's going into hospital
20 reimbursement. I mean, we have a lot of states that pay
21 very, very low on the direct care rate and I do not like
22 that disconnect between the direct services to individuals

1 that are eligible for the program that I think DSH
2 sometimes distorts.

3 But again, if there's a reduction on total DSH
4 allotment I have general funds that were supporting some of
5 that, that I could now redirect through base rates, which I
6 think is a better route to go.

7 COMMISSIONER DOUGLAS: But, Darin, wouldn't that
8 deal with how states -- not the allocations but then the
9 question about transparency on methodologies of --

10 COMMISSIONER GORDON: If you're doing it to a
11 base rate -- I mean, there's transparency on several fronts
12 here, transparency on what's being done through DSH and/or
13 supplemental payments but also transparency of really
14 what's actually being paid to a hospital for a Medicaid
15 beneficiary that is somewhat distorted. If you look at
16 direct reimbursement rates it's distorted by this kind of
17 foggier place over here in DSH that is offsetting some of
18 that. So because it's more clear if it's not in DSH the
19 more you can move it into direct reimbursement of my base
20 rates then everyone sees that much more clearly.

21 VICE CHAIR LAMPKIN: Thanks, everybody. This has
22 really been a helpful conversation. Now when we go back to

1 the task that Rob put in front of us let's see if we can
2 kind of pull the strings together and the thoughts
3 together. I've been keeping a little bit of a running
4 tally. Not everybody has weighed in but of those who have
5 weighed in it sounds like there's a little bit of a
6 preference for the low-income measure versus the uninsured,
7 which is running, you know, a second place, but not a super
8 close second place, with the third one left in the dust.

9 Okay. So I think the question for those of us,
10 like me, who preferred the uninsured measure is can we get
11 to low-income? If we can, do we need anything more from
12 Rob to help us get there? Where do we feel about that?
13 I'll start since I was one of the low-income people.

14 I think the main thing that I would like to
15 understand, and this may be useful for the other shortfall
16 concerned folks, is if we were to go to a measure like that
17 and then down the road say we think shortfall can be
18 handled elsewhere, does that produce any kind of disconnect
19 with the way the dollars have been allotted and states'
20 ability to spend them based on costs other than shortfall,
21 or is that still going to look fairly rational? To me that
22 would be useful but I could be in the low-income camp as a

1 neutral middle ground, assuming that didn't produce some
2 unexpected distortion.

3 So are there others who were in a different camp
4 who can weigh in? Darin and then Bill.

5 COMMISSIONER GORDON: Yeah. I still obviously
6 prefer the uninsured route, where I was before. If you do
7 low-income -- and I'd actually say this with regards to
8 whatever path we end up on -- the thing that I struggle
9 with, historically you make these decisions, you look at it
10 once and you don't look at it again, and there's a lot of
11 the dynamics that change. And I think DSH has been one of
12 those that we looked at, at one point in time, and it
13 hasn't changed for many, many years. If you are going to
14 look at either of these measures some kind of regular
15 occasion that you're relooking at that, because things
16 change in these states, I think would be helpful.

17 COMMISSIONER SCANLON: I don't think I had a camp
18 before, and I'm still not sure. But I think one thing I'd
19 like to know about is what would be the consequences of
20 using sort of low-income on the uninsured. Because the
21 issue here is we're not changing FMAP. We're allocating a
22 fixed pot of money. States have a lot of levers, but they

1 will use them independent, potentially, of sort of how they
2 react to this amount of money. So there's going to be a
3 consequence when you look at the low-income, states that
4 have expanded have gotten an enhanced match to expand, so
5 they're getting federal funds to help those people, and now
6 they're going to get more by using low-income for DSH as
7 opposed to what they would get with the uninsured.

8 And so I think the population that's still at
9 risk are the uninsured -- at the greatest risk. Let's put
10 it that way. And so I think knowing sort of how you change
11 what the dollars are available for the uninsured, from
12 making a choice between these two, would be an important
13 thing to know.

14 VICE CHAIR LAMPKIN: Fred.

15 COMMISSIONER CERISE: I think that's a good
16 point. Listen, I mean, there's no right answer to this. I
17 think getting away from historical allocation is a good
18 move. I mean, the DSH reductions were premised on the fact
19 that the uninsured was going to go down.

20 CHAIR THOMPSON: Across all states.

21 COMMISSIONER CERISE: Right. But, I mean, you
22 know, to go back to Alan's point, I think you can't

1 separate it from expansion and non-expansion. I mean, what
2 I hear is a push towards to say we don't want to
3 incentivize states or gives states any encouragement to not
4 expand, is sort of what I hear if we folks on the
5 uninsured, because the DSH reductions were premised on a
6 reduction on uninsured so you wouldn't need the DSH funds
7 because people were going to be on Medicaid.

8 And so I do think, still, the truest form of
9 addressing it, and states do have more leverage to address
10 Medicaid shortfalls, and you have your analysis that shows
11 the uninsured -- the number of uninsured best correlates
12 with hospital uncompensated care costs.

13 So for those reasons I think that one makes the
14 most sense. I realize there's not a perfect answer here,
15 and if the decision is to use a low-income metric, but I
16 don't think that best assesses the uninsured left in those
17 non-expansion states, those places, are going to have a
18 greater need because they're not getting the additional
19 Medicaid payments and they have fewer levers to address the
20 uninsured.

21 VICE CHAIR LAMPKIN: Melanie.

22 COMMISSIONER BELLA: I just -- I don't think that

1 we can assume that states have unlimited levers, even if it
2 relies on general fund dollars. And so I think that's just
3 a little bit of a fallacy. Well, I know, but everyone is
4 acting like with this one there's all these tools that
5 states have, and that's a reason to do it a certain way.
6 If they don't have the general fund dollars they don't have
7 any tools. And so if there was money sitting around for
8 them to increase rates they'd be dealing with access and
9 capacity issues in other ways.

10 And so I just think -- I just think we shouldn't
11 rely on that as if it's an obvious solution, because they
12 do have limited funds.

13 COMMISSIONER CERISE: And I could just tell you
14 in my state over half the hospital payments are not base
15 payments. They're supplemental payments, and those are not
16 coming from general funds.

17 COMMISSIONER BELLA: [Off microphone.]

18 COMMISSIONER CERISE: But they have options other
19 than general funds.

20 CHAIR THOMPSON: And, right. And there's an
21 interesting question about whether that gets hospitals in
22 Texas more money than expansion would have.

1 COMMISSIONER CERISE: This is not a Texas, non-
2 Texas.

3 CHAIR THOMPSON: Right. Right. It just makes
4 the point that the question of whether uninsured is the
5 thing that is given the ways in which different states
6 structure. You know, the other thing that I would just
7 point out is we just heard about the fact that we have --
8 although I know that, in theory, many of us are concerned
9 about Medicaid shortfall as an element in this equation
10 because of what Stacey mentioned, which is our preference
11 is have adequate rates to pay for covered services
12 delivered to eligible beneficiaries. The fact of the
13 matter is that we're seeing that shortfall is having an
14 effect.

15 And so I just, again, to emphasize the point
16 about trying to go to a more of a neutral measure, the
17 benefit of that being there are all these different, I
18 won't call them levers. I'll call them factors, of what's
19 happening in the state, what's traditionally happened in
20 the state, how states have thought about expansion, how
21 states have thought about payment rates, how states have
22 thought about pools.

1 And so I kind of go back to something Alan said,
2 which is, you know, do we really want to try to over-
3 engineer this, especially if, you know, there's a lot of
4 factors that are going to play into how states respond and
5 what states have been doing. And again, I reiterate,
6 that's why, in part, I think the more neutral population-
7 based measure of need is superior in staying away from some
8 of those impacts and effects and interactions.

9 VICE CHAIR LAMPKIN: Darin.

10 COMMISSIONER GORDON: Just on another point on
11 the shortfall thing that I always struggle with is that is
12 a component where -- and again, it could, depending on
13 where you look at this, it could be in the formulation on
14 how they actually distributed DSH or not -- but where
15 hospital cost, which you don't control, and, quite frankly,
16 that concerns, can have a stronger influence. And I'd like
17 to diminish the weight that has in that formula, because I
18 can't say that everyone approaches their development of
19 cost the same way.

20 CHAIR THOMPSON: Right. I'm just saying that
21 there's a lot of things I think we talked about as a
22 Commission that we want to move things in this direction

1 versus that direction, and the question of whether this is
2 the place to do it or to kind of step back and say, you
3 know, let's find something that is objective, that we have
4 a good data source on, that's neutral. We're not going to
5 be able to manage all these interactions, state by state by
6 state, in any kind of way that has any sensitivity towards
7 all of these factors and goals. So let's stay high level.

8 You know, it looks like in the results we don't
9 have a tremendous swing, although we will have a swing on
10 individual states. And I do think coming back with a
11 little bit more of some of these questions and analysis on
12 this basis can be very helpful. But that's why I think it
13 makes more sense to move in that direction.

14 VICE CHAIR LAMPKIN: Okay. Anything burning,
15 because we've used our hour on this, and I think we've made
16 -- it seems like we've made really good progress. We have
17 a measure to move forward with, maybe a few assurances and
18 extra pieces.

19 We heard a couple of comments on the timing of
20 the phase-in but they were generally positive. So does
21 anybody else need to weigh in on the phase-in approach that
22 we've seen, or that it's good to keep running with those

1 concepts?

2 [No response.]

3 VICE CHAIR LAMPKIN: All right. Great. Thanks,
4 everybody.

5 CHAIR THOMPSON: Okay. So why don't we see if
6 there's any public comment that we want to take before we
7 take a short break.

8 **### PUBLIC COMMENT**

9 * MS. GONTSCHAROW: Hi. Good morning. Zina
10 Gontscharow with America's Essential Hospitals, and we
11 thank the Commission for the opportunity to provide
12 comments today and for the Commission and its staff for its
13 thoughtful work on Medicaid DSH payments.

14 As the Commission considers recommendations to
15 Congress, America's Essential Hospitals urges the
16 Commission to clearly communicate the impacts that the
17 impending DSH reductions will have on hospitals in
18 communities across the country. The magnitude of these
19 cuts cannot be overstated, especially with the steep cliff
20 of the reduction schedule where two-thirds of the funding
21 will be wiped out within two years. This is a crucial
22 funding stream and it will be effectively gutted, a funding

1 stream that currently does not cover all uncompensated care
2 costs shouldered by essential hospitals, as confirmed by
3 the latest analysis even post-Medicaid expansion. This
4 will have a great impact on patients and the essential
5 hospitals that care for those patients. This must be made
6 clear to Congress and policymakers.

7 Further, the association urges the Commission to
8 provide recommendations around the better targeting of the
9 DSH funds to hospitals with high levels of uncompensated
10 care that also provide access to essential community
11 services. Targeting the hospitals within a state is just
12 as important as allocating the ACA-mandated DSH reductions
13 amongst the states. Targeting will be especially important
14 if the reductions to Medicaid DSH are fully implemented as
15 scheduled. They cannot be separated.

16 Thoughtful targeting is key to ensure that
17 mission-driven hospitals that currently serve a vital role
18 to their respective communities are supported. These are
19 hospitals that are committed to caring for the most
20 vulnerable, training the next generation of health care
21 leaders, providing comprehensive coordinated care,
22 providing specialized life-saving services, and advancing

1 public health.

2 America's Essential Hospitals appreciate the
3 opportunity to submit these comments and we look forward to
4 collaborating with the Commission as it continues its
5 important work on this issue.

6 Thank you.

7 CHAIR THOMPSON: Thank you for those very
8 thoughtful comments. Any other public comments at this
9 time?

10 [No response.]

11 CHAIR THOMPSON: All right. We'll adjourn and be
12 back at 11:15.

13 * [Recess.]

14 CHAIR THOMPSON: Okay. If we can get started on
15 the last session for this morning.

16 Okay. We're here to follow up on the
17 conversation that we began really in earnest at the last
18 meeting on working and community engagement requirements,
19 focusing on what's happening in Arkansas since that's our
20 live demonstration at the moment. So, Kacey, you have a
21 presentation that responds to, you know, a lot of the
22 questions that the Commissioners were asking at our last

1 session. We're going to let you go through that, and then
2 we're going to kick off Commissioner conversation in
3 response.

4 **### UPDATE ON IMPLEMENTATION OF WORK AND COMMUNITY**
5 **ENGAGEMENT REQUIREMENTS IN ARKANSAS**

6 * MS. BUDERI: Great. Okay. So today we'll
7 continue our discussion of Medicaid work and community
8 engagement requirements focusing on Arkansas, which is the
9 only state with requirements currently in effect. And as
10 you said, Penny, at the September meeting Commissioners
11 expressed concern about initial data showing that 4,300
12 people had lost coverage following noncompliance in the
13 month of August. And the Commission had a number of
14 questions about the state's approach to implementation and
15 some of the challenges with it.

16 So today I'll be providing you with some
17 additional information on the areas you flagged, and this
18 presentation draws from publicly available sources and
19 conversations we've had with people in Arkansas who include
20 staff from the Arkansas Department of Human Services; the
21 Arkansas Foundation for Medical Care, which is the state's
22 beneficiary relations contractor; Arkansas Blue Cross Blue

1 Shield; and Arkansas Advocates for Children and Families;
2 and then we've also spoken with CMS, the Centers for
3 Medicare & Medicaid Services.

4 I'm also going to talk about some of the data
5 that Arkansas released in its latest monthly compliance
6 report which shows an additional 4,100 people were
7 disenrolled for noncompliance in September.

8 So I'll start by providing some background on
9 Arkansas' work requirement policy. I'll discuss the
10 compliance data for the first four months of the program
11 and some of the implications. And then I'll talk about
12 some of the outreach and education strategies the state and
13 its partners are engaged in, challenges that remain for
14 beneficiaries with regard to reporting, and efforts being
15 made to connect beneficiaries with supportive resources.
16 I'll also talk about oversight requirements, including
17 monitoring and evaluation and CMS' role, and I'll conclude
18 by describing some next steps which, as we discussed at the
19 September meeting, could include a letter to CMS.

20 So as a refresher, requirements in Arkansas
21 currently apply to members of the new adult group age 30 to
22 49 with incomes below 100 percent of the federal poverty

1 level. Next year, Arkansas will begin phasing in the
2 requirements to beneficiaries age 19 to 29. Individuals
3 subject to requirements must either qualify for an
4 exemption or report work activities. Some of the
5 exemptions are automatic, meaning the state can identify
6 them with administrative data and action is not required by
7 the beneficiary. Individuals without an automatic
8 exemption need to report information each month through an
9 online portal. They can either report an exemption not
10 previously identified by the state, or they can report at
11 least 80 hours of work or qualifying activities.

12 Beneficiaries who fail to meet these requirements are
13 disenrolled after three months of noncompliance in the
14 calendar year, and then they are locked out of the coverage
15 for the remainder of the year. They cannot re-enroll
16 unless they qualify for another Medicaid eligibility
17 pathway or receive a good cause exemption, which is a
18 retroactive exemption intended for people who experience
19 some type of temporary hardship.

20 Okay. So though it's not required to do so by
21 the special terms and conditions of the waiver, Arkansas is
22 releasing monthly reports with information on compliance.

1 You saw a version of this figure at the September meeting,
2 and it now includes the latest information which was
3 released last week. And as you can see here, we have data
4 for June through September. The state phased in enrollees
5 in groups, which is why you're seeing an increasing number
6 of individuals subject to the requirements.

7 Across all four months, they show that most
8 beneficiaries had an automatic exemption, which is the
9 green part of those bars, and then of those who did not,
10 most were noncompliant, who are the light blue portion of
11 those bars.

12 So the Commissioners had a number of questions
13 about this data at the last meeting, and I'm going to
14 discuss it in greater detail in the coming slides. I'm
15 going to primarily refer to September data because it's the
16 most recent and it includes the most enrollees. In
17 general, all proportions held across the four months, but
18 I'll note any changes.

19 Since September, about three-quarters of
20 beneficiaries subject to the requirement had an exemption.
21 Ninety-six percent of those exemptions were automatic,
22 meaning that beneficiaries did not need to report anything

1 through the portal. The remaining 4 percent were reported
2 through the portal.

3 The most common exemption was having income
4 consistent with working 80 hours or more per month at
5 Arkansas minimum wage, and about half or 46 percent of
6 exempt enrollees were in this group. Exempt enrollees.
7 The other half was primarily made up of people who were
8 exempt from SNAP work requirements, who were determined
9 medically frail, or had a dependent child, with a small
10 number falling into other exemption categories.

11 In our conversations with people in Arkansas,
12 some noted that the exemption policies were a source of
13 confusion for beneficiaries. For example, beneficiaries
14 might see a list of exemptions and not realize that they
15 need to go in and report that exemption. And, also, the
16 exemptions are valid for different lengths of time, meaning
17 that people might not realize when they need to go back
18 into the portal and update that exemption.

19 And so for the beneficiaries who were not exempt,
20 which was about a quarter of beneficiaries in September, 8
21 percent complied with the requirements. Of these, two-
22 thirds were identified as compliant through SNAP work

1 requirements. They were identified as compliant with SNAP
2 work requirements through a data match, so they did not
3 actually report anything through the portal.

4 The remainder did report through the portal, and
5 the most commonly reported activity was work, either alone
6 or in combination with another activity, but DHS does not
7 track through the portal whether these work activities are
8 associated with new or existing employment.

9 Of those who were noncompliant, which was about
10 91 percent of beneficiaries without exemptions, 99 percent
11 were noncompliant because they reported no work activities
12 through the portal, and the remaining 1 percent reported
13 fewer than 80 hours of activities.

14 According to DHS, they do have data on
15 beneficiaries who start the process of creating an account
16 but don't enter information, and they share this with AFMC,
17 Arkansas Foundation for Medical Care, but neither DHS nor
18 AFMC described a systematic process for using that
19 information, and they didn't share the data with MACPAC.

20 So as of October 8th, 8,462 individuals had been
21 noncompliant for three months and were disenrolled, and
22 this total represents about 19 percent of beneficiaries who

1 have been subject to the requirement for three months or
2 more or 62 percent of those without an exemption. An
3 additional 12,580 beneficiaries are currently at risk for
4 disenrollment in future months because they have been
5 noncompliant for one or two months.

6 So Commissioners were interested in how these
7 coverage loss figures compared to other disenrollment
8 reasons. So looking at reasons for disenrollment from
9 Arkansas Works, which, as a reminder, is Arkansas's
10 expansion program, noncompliance with the work requirement
11 was the most common reason for disenrollment in September
12 and the second most common in August, making up 27 and 24
13 percent of Arkansas Works disenrollments respectively.

14 I'll note that the comparison here gets a little
15 bit tricky because not all Arkansas Works beneficiaries
16 could be disenrolled for noncompliance with the work
17 requirements in those months, only people who had been
18 subject to the requirement for at least three months could;
19 whereas, all Arkansas Works beneficiaries could be
20 disenrolled for other reasons.

21 The disenrollment rates are comparable or higher
22 than disenrollment rates in states with waiver policies

1 that require premiums as a condition of eligibility. For
2 example, as I mentioned, about 19 percent of beneficiaries
3 subject to the requirements for three months were
4 disenrolled for noncompliance, and this is about equal to
5 the 18 percent of Indiana Medicaid expansion enrollees who
6 were required to pay premiums and were disenrolled for
7 nonpayment in 2017. However, other states with similar
8 policies, including Montana and Iowa, had much lower rates
9 of disenrollment.

10 So you asked at the September meeting about some
11 of the implications of disenrollment. When beneficiaries
12 are disenrolled, they receive a notice that contains
13 information on how to apply for a good cause exemption, the
14 circumstances under which they may be able to qualify for
15 Medicaid through a different pathway or advance premium tax
16 credits, and where to access free or low-cost health
17 services. However, the state is not currently analyzing
18 whether beneficiaries gain other sources of coverage or
19 what kinds, or whether people are accessing care through
20 the sources noted in the disenrollment notice.

21 The state is tracking beneficiaries who apply for
22 and receive good cause exemptions, and the number that

1 applied was very low at first. It was none in June, four
2 in July, and then that grew in August, reaching 246 in
3 September, and the state has been granting the majority of
4 those requests.

5 The characteristics of disenrolled beneficiaries,
6 for example, their health status, those are unknown because
7 the state is not currently analyzing data on this, and we
8 also didn't hear any anecdotal reports on this.

9 The state is not currently collecting data on any
10 downstream effects of coverage losses, for example, effects
11 on the safety net, uncompensated care, or health plan risk
12 pools.

13 So to better understand some of the factors
14 leading to low rates of compliance and the high
15 disenrollment numbers, Commissioners wanted to learn more
16 about the outreach and education activities being conducted
17 by the state and its partners. So DHS leads an outreach
18 and education strategy. They send formal notices to
19 beneficiaries through postal and electronic mail at various
20 stages of the process. DHS has also made resources
21 available in print, such as flyers and postcards, and
22 online, such as instructional videos. However, most direct

1 outreach to beneficiaries is conducted by AFMC and the
2 exchange plans. And so AFMC makes outgoing calls to new
3 and existing beneficiaries who are scheduled to begin
4 compliance in the following month, and they have a quota
5 for the share of beneficiaries that is expected to reach
6 and speak with. It also operates a call center where it
7 gets incoming calls.

8 Exchange plans have no formal outreach
9 obligations, but they are doing things like making calls,
10 sending text messages and emails, distributing educational
11 materials. They have been working on training their call
12 agents to assist beneficiaries with understanding the
13 requirements.

14 DHS and exchange plans have also done outreach
15 work with providers, beneficiary advocates, and other
16 stakeholder groups to help prepare them to help
17 beneficiaries with the requirements.

18 Despite these efforts, however, there was a
19 general consensus that beneficiary awareness of the
20 requirements is low, and this is consistent with what other
21 researchers have found. The people we spoke to cited a
22 number of different contributors to low awareness, which

1 are listed on this slide. For example, the program is new,
2 and the implementation timeline was tight. It was less
3 than three months from approval to the go-live date. And
4 while some of the preparations for implementation had begun
5 prior to the waiver approval, none of the beneficiary
6 outreach was happening until after the waiver was approved.

7 Also, the population is difficult to reach. AFMC
8 and DHS were able to provide us with some data on this
9 which showed that AFMC was able to reach about 23 percent
10 of the target group of beneficiaries in each month for the
11 first three months. The most common reasons for not being
12 able to reach beneficiaries were not having a phone number
13 available or having a bad number. The share of
14 beneficiaries they could reach went up in September and
15 October to about 50 percent, and this was likely because
16 they switched from contacting existing and new enrollees to
17 only contacting new enrollees whose constant information is
18 newer and more reliable.

19 The exchange plan premium assistance program was
20 also cited. Many beneficiaries were auto-enrolled in
21 Medicaid and then auto-assigned to plans like Blue Cross
22 Blue Shield or Ambetter, and some of the people we spoke to

1 noted that they just don't have experience taking action
2 regarding their health coverage. And then several people
3 also noted that they might not even know they have Medicaid
4 coverage.

5 Some of the beneficiary advocates also said that,
6 despite the efforts being made, the outreach materials
7 themselves and educational materials were not actually
8 designed well with this population in mind. The notices
9 and instructions going out to beneficiaries, they noted,
10 were long and overly technical. Many of the resources,
11 like the instructional videos, are available online, and so
12 they're out of reach to many people in Arkansas. And the
13 language, they also noted, lacked attention to some of the
14 known issues like beneficiaries not knowing they have
15 Medicaid.

16 So besides low awareness, another factor that has
17 been talked about as a contributor to low compliance has
18 been the portal itself and the challenges that it creates
19 for beneficiaries. So as a reminder, the portal is the
20 only way beneficiaries can report compliance information.
21 Normally states are required to allow beneficiaries to
22 submit information related to eligibility through multiple

1 different means, but CMS waived this requirement for
2 Arkansas. This approach does minimize state resources, but
3 it has some characteristics that make it difficult to use
4 on the beneficiary side.

5 Notably, it require Internet access, which is a
6 challenge in Arkansas, which has one of the lowest rates of
7 Internet access in the country. Setting up an account
8 requires a reference number mailed to the address on file,
9 though beneficiaries can request it through the AFMC call
10 center. Set-up also needs to be done on a computer,
11 although subsequent reporting can be done on a mobile
12 device. The portal is only open for reporting from 7:00
13 a.m. to 9:00 p.m. daily, and media and anecdotal reports
14 have also indicated that it is regularly down for
15 maintenance on weekends. There was also a major system
16 outage in September right before the deadline for
17 reporting. Some of the people we spoke to also called the
18 portal slow, difficult to navigate, and not visually
19 appealing.

20 Arkansas has put in some resources to help
21 beneficiaries overcome these challenges. Beneficiaries can
22 call or receive in-person assistance from the county

1 eligibility office, who can walk them through the reporting
2 process. They can also call into the AFMC call center
3 where agents can answer questions about the process. AFMC
4 can also make warm hand-offs to the county eligibility
5 office or to the health plan.

6 Arkansas also set up a registered reporter
7 process which allows a designated individual to report on
8 behalf of an enrollee, and registered reporters are
9 typically health plan staff, but other types of registered
10 reporters include church and community leaders, family
11 members, and friends. There were about 250 registered
12 reporters as of September.

13 It's unclear whether beneficiaries are using
14 these resources because help provided by county staff is
15 not currently being tracked and neither is the number of
16 people who had their compliance information reported by a
17 registered reporter.

18 So going on to discuss work supports and other
19 resources, CMS has specified that Medicaid funds cannot be
20 used to actually provide these services to beneficiaries.
21 However, Arkansas has done some work to connect
22 beneficiaries with those offered through other programs or

1 organizations.

2 One of the things that DHS does is make automatic
3 referrals to the Department of Workforce Services at
4 eligibility determination and renewal, and they have been
5 actually doing this since 2016, so prior to the work
6 requirement.

7 Once this referral is made, DWS sends a follow-up
8 letter to the beneficiary describing its services and how
9 to take advantage of them, and the beneficiary can decide
10 whether to take advantage of the services offered. AFMC
11 can also do warm transfers to DWS if a beneficiary
12 indicates interest in these services.

13 Through a data-sharing agreement with DWS, DHS
14 has data on whether beneficiaries access services or gain
15 new employment. However, the only data on this that's
16 publicly available is from prior to the work requirement
17 taking effect, and we've asked DHS for newer data, but they
18 weren't able to provide it to us.

19 The degree to which jobs are available also has
20 been cited as a concern in Arkansas and other states
21 proposing Medicaid work requirements. And in Arkansas, it
22 varies by geographic area, so Arkansas has five counties

1 that have been designated as labor surplus areas, although
2 its overall unemployment rate is lower than the U.S. as a
3 whole.

4 Arkansas beneficiaries also face barriers to
5 work, and, in particular, these are those related to
6 transportation or child care needs and lack of Internet
7 access. And DHS publishes information online about where
8 to access resources to address these and other barriers,
9 but does not make referrals to organizations providing
10 these services and neither does AFMC. The resources
11 themselves are limited in rural areas of the state, and DHS
12 is not currently collecting data on beneficiary need for,
13 access to, or use of these services.

14 So now I'm going to shift towards talking about
15 oversight of the demonstration.

16 As a Section 1115 demonstration, Arkansas' waiver
17 program, including its work and community engagement
18 program, is subject to evaluation and ongoing monitoring.
19 So the STCs require formal independent evaluation to
20 measure the hypothesis that work requirements will increase
21 health and well-being, the effects of the requirement on
22 beneficiaries' ability to obtain employment, and the degree

1 to which individuals can transition to other sources of
2 health coverage and how this transition affects health.

3 An interim evaluation is due to CMS December
4 2020, but it's not clear when that will be made publicly
5 available. At this point, Arkansas has submitted a draft
6 evaluation design to CMS, but it has not been approved or
7 made publicly available. And Arkansas is actually still in
8 the process of procuring an evaluator, so it's unclear what
9 kind of baseline data is being collected, what specific
10 methods will be used, or what specifically will be
11 examined.

12 In addition to this evaluation, which we don't
13 expect for a fair amount of time, Arkansas does submit
14 quarterly monitoring reports that provide updates on
15 implementation and ongoing operations. They include
16 compliance and disenrollment data as well as information on
17 state outreach activities. However, they do not include
18 information looking at transitions to work or other sources
19 of health coverage, measures of health or access, or use of
20 DWS or other supportive resources.

21 CMS and DHS also have regular monitoring calls
22 where they go over data, report findings, ask questions,

1 and discuss concerns.

2 So the STCs, the special terms and conditions, of
3 Arkansas' waiver do not include any triggers or specific
4 language about the circumstances under which CMS might
5 intervene in the demonstration. However, CMS can suspend
6 or terminate demonstrations at any time.

7 There are a few instances where CMS has taken
8 action in response to concerns about beneficiary harm. One
9 example, CMS twice delayed approval of Iowa's managed care
10 transition, citing concerns about network adequacy,
11 possible disruptions in care, and feedback from
12 beneficiaries and stakeholders about the state's
13 communication strategy.

14 So, to wrap it up, I will note again that
15 Arkansas is the only state with these requirements
16 currently in effect, although two others, Indiana and New
17 Hampshire, are approved to go ahead with implementation
18 next year.

19 And you can see here on this slide where some of
20 the differences are, which include a longer implementation
21 timeline, multiple means of reporting, and lack of a lock-
22 out period.

1 And in terms of other similar requirements and
2 demonstrations coming down the pipeline, 10 other states
3 have formally submitted applications to CMS. They include
4 Alabama, Arizona, Kansas, Michigan, Mississippi, Maine,
5 Ohio, South Dakota, Wisconsin, and Utah.

6 Kentucky's waiver, which was initially approved
7 but then vacated by a court ruling, is also at CMS for
8 consideration right now.

9 Then in addition to those states, several other
10 states are at different stages of considering applying for
11 these requirements, but they haven't actually submitted a
12 formal request to CMS. For example, I know Oklahoma,
13 Idaho, and South Carolina have all talked about this.
14 There are others as well, and then I believe Virginia just
15 closed their state public comment period.

16 So, as we discussed at the September meeting, our
17 next step could be to draft a letter to CMS expressing the
18 Commission's concerns about the coverage losses in Arkansas
19 and any other areas the Commission wishes to highlight, and
20 staff will continue to monitor Arkansas' and other states'
21 implementation progress and any new reporting comes out.

22 And I will stop there and turn it back over to

1 you guys.

2 CHAIR THOMPSON: All right. Thank you, Kacey.

3 Just to let members of the public know how we're
4 going to go about this conversation, we're going to have a
5 discussion among the Commissioners. We will open it up for
6 public comment, and then we'll come back to conclude our
7 Commissioner conversation. So you guys will have an
8 opportunity to engage with us in the middle of this.

9 I'm going to kick us off, and then we're going to
10 go to Alan, Chuck, and then Darin to get this conversation
11 going, and then we'll see if others want to weigh in as
12 well.

13 First of all, thank you, Kacey. I know we gave
14 you -- we had a barrage of questions that we had, and you
15 did great in trying to go out and collect the information
16 that you were able to collect.

17 I'd say I have a dozen comments or questions of a
18 technical nature on some of the information that you
19 collected, but that's not how I want to use my time because
20 I don't think actually the answers to any of those
21 questions affect kind of where I land on this at this
22 point.

1 I am less interested in -- it's very unusual for
2 this Commission to have a conversation about a single state
3 implementation and to interject itself in what's happening
4 in a single state.

5 Now, it happens that we're doing that in this
6 case because Arkansas happens to have been the state that
7 went live first on a topic of considerable interest, and I
8 think that while there are strong feelings about work
9 requirements, pro and con, both people who support them and
10 people who don't support them would agree it's a
11 significant program feature and change. So, of course,
12 we're interested in the first-out-of-the-gate state.

13 Any state that went first out of the gate was
14 going to experience some special scrutiny and some special
15 challenges, so I think there's some things, as I look at
16 this, that I think Arkansas has done a good job at, some
17 other things that may be inherent challenges within this
18 process in and of itself, some things they maybe could have
19 done differently.

20 What I'm more interested in is having the
21 Commission weigh in on how do we think about this in terms
22 of lessons and applications to the group of other states

1 that are moving in the wake of Arkansas as well as Arkansas
2 itself.

3 I want to just tether my comments to something
4 that the Commission has spoken about before, which is our
5 ability to harvest lessons and insights from 1115 waivers
6 in a way that's timely and transparent and useful in a
7 practical way to other people contemplating some of those
8 same kinds of program features and design options.

9 In this case, we have a number of states who will
10 be moving again to implement a very new program feature and
11 approach in a very short amount of time, and this is not
12 something that we've been great at, even when we had time
13 and even when there was a long evolution of thinking. I'm
14 reminded, for example, of managed long-term services and
15 supports, where you had some states coming in to move
16 populations into MLTSS. There would be experiences and
17 implementation issues, and then the federal government for
18 the next state would add some more special terms and
19 conditions. Then that state would have certain kinds of
20 experiences and challenges, and then the next state would
21 come in -- I mean, it wasn't quite this linear, but the
22 next state would come in, and there would be more special

1 terms and conditions because there would be new challenges
2 and lessons learned.

3 That had its advantages and disadvantages. The
4 advantage was that there was some learning over time, some
5 changes in federal policy, some strengthening of
6 beneficiary protections. On the other hand, states would
7 complain that every time they came in to do one of these,
8 there was kind of a new set of rules from the federal
9 government about what the requirements were.

10 In this case, we have potentially a much more
11 truncated -- depending on what happens with this other
12 group of 10 states that are coming along, potentially a
13 much more truncated amount of time from which to harvest
14 lessons, understand what works, understand what states
15 should be thinking about, understand how to evaluate in an
16 early way whether these waivers are achieving their desired
17 results or not. And it's that subject that I would like
18 the Commission to weigh in on and potentially talk to CMS
19 in a letter and maybe with an issue brief around what are
20 the things that ought to be thought about here and how do
21 you create a rubric or a framework for a conversation
22 around what we expect to see happen in terms of process and

1 results, how do we start getting information as early as
2 possible about impacts, what are the kinds of indicators or
3 measures that would suggest that things are going well or
4 we have a problem.

5 And I think it's the absence of some of that
6 early framework and rubric, appreciating that we want to
7 see an evaluation, but it's going to take some time for an
8 evaluation to produce results.

9 How do we engage in kind of a rapid cycle
10 feedback mechanism to really understand what's going on in
11 these states as they do implementations and what kinds of
12 things they need to be collecting data on, reporting on,
13 what are the measures that would suggest we ought to have
14 concerns?

15 I think in this case, we have places where we
16 would like to have information and we don't. We have
17 certain information that may suggest certain conclusions,
18 but those may not be shared by everyone interpreting that
19 same data. And so then I think it becomes very difficult
20 to have a really focused conversation around what do we
21 think about what's happening in this particular state or
22 that particular state or how important do we think it is

1 for the federal government to have a special term and
2 condition relating to this aspect of the demonstration
3 versus that aspect of the demonstration.

4 And I think in this circumstance, where we're
5 talking about a very significant program feature and
6 change, a very substantial number of states that are
7 interested in pursuing that in a limited period of time,
8 the stakes are very high, and there needs to be a very
9 close scrutiny and agreement around what is the framework
10 for monitoring and assessing progress and results. And
11 that's kind of where I'd like to see the Commission focus
12 its attention.

13 So let me stop there and turn to Alan and then
14 Chuck and Darin.

15 COMMISSIONER WEIL: Thank you, Penny.

16 I will try to be concise, but I can't promise
17 I'll be brief.

18 There are those who believe that the social
19 contract requires people to work or otherwise be engaged in
20 order to deserve medical assistance. That, however, is not
21 embodied in the Medicaid statute as an eligibility
22 criterion, and so we move into the realm of research and

1 demonstration to test a hypothesis.

2 A hypothesis, as I understand it loosely, is that
3 withholding Medicaid coverage will motivate people who
4 would otherwise be disconnected from work and other
5 activities to become engaged.

6 I've spent my career in health and social policy,
7 and there's not any evidence that I'm aware of to support
8 the hypothesis. So this is an opportunity to generate the
9 data and evidence that enable us to test that hypothesis.

10 Over the life of Medicaid and welfare, which I
11 have also studied, there have been a lot of experiments,
12 and they've covered a lot of topics, including things that
13 potentially could harm people who are the intended
14 recipients of those programs.

15 As Kacey notes, the rates of disenrollment that
16 we're seeing here are higher than, for example, charging
17 premiums or other things that have potentially restricted
18 people's access to care, and so that immediately sends up
19 some caution that suggests the stakes here are unusually
20 high.

21 As a Commissioner, I'm focused -- I think, Penny
22 as you, but I'm going to end in a somewhat different place

1 -- on the question of what do we learn, and here's what I'm
2 hearing from the materials given and, Kacey, your
3 presentation. Acknowledging that a lot of the transparency
4 is voluntary on the part of the state -- and I don't want
5 to beat them up for telling us things and then us using
6 them against them, but this is what I hear.

7 I don't see a robust research plan that will
8 answer the question of whether or not the hypothesis is
9 true. I don't see any efforts to randomize. This could
10 have been rolled out by region. To my knowledge, they're
11 not collecting data on the age groups that have not been
12 brought in, which could give you a phased-in implementation
13 that would give you some comparison groups.

14 What you're telling us about the status of the
15 state-based evaluation and the limited information
16 available about the federal evaluation does not give me
17 much confidence that we're actually going to be able to
18 determine whether or not the hypothesis is true.

19 I don't see new investment in the work supports
20 that are needed. A referral is something that from the
21 welfare evidence is not in and of itself likely to be
22 effective.

1 From what I gather, there's very limited data
2 collection regarding the actual people, and this isn't that
3 many people. We don't know what they're engaging in. We
4 don't know if their work efforts are new or their work with
5 the workforce services is new. We, to my knowledge, are
6 not asking any questions about their well-being, their
7 income. These are all things, I should just say, that are
8 part of the long series of research that was conducted
9 prior to welfare reform, for example, literature I'm quite
10 familiar with.

11 There are lots of operational issues that are
12 being raised, and as someone who used to run a Medicaid
13 agency, I respect the challenges associated with the change
14 we're making. But one of the principles of administration
15 is to try to have the burden of operational challenges not
16 fall on the most vulnerable beneficiaries, but instead be
17 something you try to work through behind the scenes. I do
18 get the sense that time may make some of these better.

19 I am particularly concerned by the ratio of
20 people potentially harmed to those who are potentially
21 helped. So when I see very small numbers of people exempt
22 through the portal, but then very high rates of good-cause

1 exemptions when they're applied for, that suggests to me
2 that these terms of "compliant" and "noncompliant" are
3 fiction. That the reality on the ground does not match the
4 administrative data that we are collecting, and that to me
5 is a big red flag for whether or not we're actually asking
6 the right question.

7 I completely respect the notion that change is
8 disruptive, and I agree -- I would use the same example,
9 Penny, as you did, with respect to moving complex
10 populations to managed care. Some level of disruption is
11 inevitable. Some people will likely be worse off in the
12 change. There's got to be some prior that you have about
13 the balance of disruption or the ratio of disruption to the
14 people who will benefit.

15 So what I am seeing in addition to a lot of
16 people losing coverage is I'm not seeing evidence that will
17 answer the question of whether or not the hypothesis is
18 true, and that actually concerns me greatly. So I go back
19 to our statute. I guess that's what you do when you're a
20 lawyer. We are to review and assess Medicaid and CHIP
21 eligibility policies, including a determination to the
22 degree to which federal and state policies provide health

1 care coverage to needy populations. I don't think anyone
2 is questioning whether or not the population affected by
3 this is needy.

4 So the question is, what do we do about this? I
5 don't have the answer. I talked to some people in the
6 audience. I am looking forward to audience comment.

7 This is what I would say. At this point, I think
8 it is appropriate to say that no additional state should
9 initiate this policy -- and I realize that that's a loose
10 term -- absent one of two things, either some promising
11 data, which I am not yet seeing out of what's happening in
12 Arkansas, or a much more robust research protocol than is
13 in place here.

14 And I'm going to differ, Penny, with you with
15 respect to rapid cycle improvement. To me, rapid cycle
16 improvement is about improving operations. It's about
17 making the program work. I'm more concerned that the
18 fundamental hypothesis that underlies the experiment is not
19 -- we're not going to have data to know whether or not it's
20 true, and so I don't -- making something work better, if
21 the premise on which it's built is flawed is better than
22 not making it work better, but to me, those are somewhat

1 different issues, and so I don't want to just treat this as
2 an operational problem.

3 I think the harder question is, what's the
4 message to the Secretary, and what's the message to the
5 state? I guess I want to withhold judgment, hearing from
6 colleagues, but at this point, it's very difficult for me
7 as a member of this group, with the charge that we have, to
8 simply say, "We're going to wait. We're going to see how
9 many more people lose coverage. We're going to wait for a
10 few years to find out whether or not who of them did better
11 and who did worse," and that some pulling of the alarm is
12 essential. The nature of that, I'm going to withhold on,
13 but the notion of saying we're going to stay out of it
14 because it's one state, that does not feel appropriate to
15 me at this point.

16 CHAIR THOMPSON: Thank you, Alan.

17 I did not mean on rapid cycle feedback that it
18 was only operational, so I do think that it is about
19 getting some sense of what's happening to individuals and,
20 again, in support of developing that baseline and
21 intermediate evaluative points that can give us a sense
22 about whether we're more likely than not to be seeing

1 ourselves as achieving our objectives.

2 But thank you for that point as well.

3 All right. Chuck.

4 COMMISSIONER MILLIGAN: I will try to be concise,
5 and I don't promise I'll be brief.

6 [Laughter.]

7 CHAIR THOMPSON: That is going to be the line all
8 of us are going to use for the rest of our lives.

9 COMMISSIONER MILLIGAN: I always like stealing
10 Alan's stuff.

11 [Laughter.]

12 COMMISSIONER MILLIGAN: So I had a couple of
13 questions actually, Kacey, and then I will have some
14 comments.

15 One of my questions is -- if you don't mind going
16 to Slide 9? Yep, this one. I think this one.

17 So the bottom part of the slide, you mention
18 12,000 beneficiaries at risk, 4,841 with two months of
19 noncompliance, so they might have a third month of
20 noncompliance, 7,748 with one month. Do these individuals
21 who are one month or two month noncompliant, do they get a
22 notice of any type at the time?

1 MS. BUDERI: They do get a notice from -- a
2 formal notice from DHS mailed to their home postal or, if
3 on file, an email address.

4 COMMISSIONER MILLIGAN: Okay. And does that
5 notice include the information around good-cause exemptions
6 or how to apply for good-cause exemptions? What is
7 contained in that notice that would prompt them, if
8 anything, to have evidence of a good cause exemption and
9 all of that kind of stuff?

10 MS. BUDERI: It's my understanding that
11 information on applying for a good cause exemption is only
12 included in the disenrollment notice, after you've already
13 been disenrolled.

14 COMMISSIONER MILLIGAN: So if they're one month
15 into three months of being noncompliant, or two months into
16 three months, they don't get notice of how to pursue a good
17 cause exemption before that disenrollment notice happens?

18 MS. BUDERI: That's my understanding.

19 COMMISSIONER MILLIGAN: There was one other
20 question that I had, and then I'll kind of go into a few
21 things. When you talked about the portal you said that
22 they are mailed some kind of code about how to create an

1 account. Do we know how many of the addresses the states
2 are using are bad addresses? Do we know how much -- you
3 talked about low awareness, low information by a lot of the
4 beneficiaries, that they're not -- that all of the people
5 you interviewed generally said that there's a low level of
6 awareness by the beneficiaries. Do we know how much the
7 mail gets through to these folks, how good the addresses
8 are? Do we know that?

9 MS. BUDERI: I haven't seen any data on how good
10 the addresses are. The only thing I've seen kind of on
11 that line is how many phone calls went through, like how
12 many phone numbers were good.

13 COMMISSIONER MILLIGAN: So it's the phone
14 outreach, but it's the mail outreach in terms of the portal
15 access that they need.

16 MS. BUDERI: Right.

17 COMMISSIONER MILLIGAN: Okay. So I want to
18 start, in terms of just comments, in a somewhat separate
19 place. If we can look at Slide 5, if you don't mind -- I
20 promise we won't keep bouncing around with slides. One of
21 my thoughts about this is when I did the math it looks like
22 77 percent of the people are not considered noncompliant.

1 We've got -- so, I'm sorry. Slide 5 has the bar chart?

2 Okay. Thank you.

3 So 52,000 people, the state identified an
4 exemption; 2,200-and-something people reported an
5 exemption; 1,500-and-something people complied with the
6 work requirement. So I did the math. That's 77 percent of
7 this group, their coverage is intact. And then the 16,757
8 are at risk. That's what this looks like to me.

9 MS. BUDERI: That's correct.

10 COMMISSIONER MILLIGAN: Okay. So I guess I want
11 to say two things, high-level policy. One is I do want to
12 acknowledge that Arkansas is publishing data, which they
13 didn't have to do, and so I want to commend Arkansas for
14 doing that.

15 The second kind of just broad-level comment I
16 want to make is there are a lot of states that might not do
17 the Medicaid expansion but for politically doing some kind
18 of work requirements, and so I do think -- and I will have
19 some comments about where I think there needs to be some
20 process improvements, at a broader national waiver
21 discussion level and less about Arkansas. But I do think
22 that I don't want to lose sight of the fact that 56,509

1 people are getting coverage who might not get coverage if a
2 state was required, politically or otherwise, to link a
3 work requirement in order to do a Medicaid expansion.

4 I know we had a little bit of this conversation
5 in September and it's not quite 1-to-1, the way I'm saying
6 it. I want to be careful that it's not a 1-to-1
7 correlation between states that do work requirement and as
8 a condition of doing a Medicaid expansion. But I know that
9 in a lot of states they wouldn't do the Medicaid expansion
10 if they couldn't do some version of a waiver like this, and
11 to the extent that those dynamics were in play in Arkansas
12 there are 56,509 people getting coverage who might not if
13 the state had to do a work requirement, politically, to
14 pursue this kind of Medicaid expansion.

15 So I guess I want to partly see the glass as half
16 full here, just contextually. To me, in terms of the
17 national discussion about work requirements and community
18 engagement and waivers, my concerns about what your data
19 show here is that I think whenever a state rolls something
20 like this out the beneficiaries need to have an opportunity
21 to know about it, to comply with it, and to succeed within
22 whatever the rules are the state establishes. I think the

1 beneficiaries have to have that opportunity to know,
2 comply, succeed.

3 And, to me, my concerns are in some ways less
4 about the policy and more about the procedure piece of
5 this, because, to me, the good cause notices, how to apply
6 for a good cause exemption, let me put it that way, they
7 come too late in the process if they're coming with the
8 disenrollment, and I think that that, as a procedure, is
9 too late to allow beneficiaries to, within their rights,
10 avail themselves of that good cause exemption. So that's
11 one procedural piece that I think doesn't give the
12 beneficiary an opportunity to succeed within the rules the
13 state is establishing.

14 To me the second part of that is, I think that
15 there needs to be enough emphasis on member awareness,
16 member education, beneficiary notices. I think there needs
17 to be a stronger educational campaign piece of this if
18 states are pursuing these kinds of waivers, to raise that
19 awareness level to bring beneficiaries into knowledge. And
20 one of the comments you made when you did your presentation
21 was a lot of these folks aren't really accustomed to kind
22 of how to -- they're not getting notices, they were auto-

1 enrolled in certain products, all of that kind of stuff.
2 So I think the awareness piece needs to be more of a
3 requirement to the extent that states are pursuing this
4 kind of thing.

5 I think the way the portal is handled doesn't put
6 the beneficiaries in a position to succeed, to comply with
7 the state's policy, to succeed within the rules of the game
8 the state establishes, partly because of the code only
9 being part of the mailing. The code isn't apparently
10 included in those phone call outreaches that are done by
11 AFMC, and they're not apparently part of outreach calls.

12 And so, to me, the way that beneficiaries seem to
13 be aware of how to create an account, how to use the portal
14 doesn't put people in a position to succeed. The internet
15 issue is a part of that. The hours of coverage of the
16 portal are part of that. And so if you're going to use
17 that kind of methodology by which people report it needs to
18 be, to me, at a procedural level, done in such a way that
19 beneficiaries have a stronger opportunity to succeed within
20 the rules the state is establishing.

21 And I think I had one other comment I wanted to
22 make, and I want to go back to my notes about this. No, I

1 think, actually, I've covered off on it. Just to sum up,
2 I'm not going to take issue with the policy here in
3 Arkansas. I do think there are a lot of states that would
4 only do the Medicaid expansion if they could do this kind
5 of thing, and we've seen in the data you presented in
6 September 77 percent of the people who are subject to this,
7 their coverage hasn't been put at risk yet. So that's a
8 win for those people and I don't want to lose sight of
9 that.

10 But I do think to the extent the states pursue
11 this kind of thing, MACPAC's role, in my view and my
12 opinion about this is our advice to CMS ought to be that
13 they require states to follow procedural dimensions in
14 terms of communication protocols, good cause exemption
15 notices, all of that in a way that put the beneficiaries in
16 the best position to know the program, to comply with the
17 program, and to succeed within the rules of the road the
18 state establishes, and to me that's the deficit in Arkansas
19 that I think I would like to see CMS become more strict
20 about in terms of the terms and conditions for future
21 waiver approvals. And I'll leave it there. Thank you.

22 CHAIR THOMPSON: Thank you, Chuck. Just to

1 follow up on Chuck's point, Kacey, can we go to the slide
2 where you talked about the other states that have been
3 approved? I think this is something to think about.

4 In either Arkansas' or Indiana's or New
5 Hampshire's waiver applications or STCs, do we have visible
6 the kinds of dimensions that you spoke to you in your paper
7 and the things that Chuck is reacting to? In other words,
8 would you know, from reviewing either the waiver as it was
9 submitted, or the approval document that CMS provided, how
10 a state was going to handle good cause exemptions, or hours
11 of a portal, or the availability of various channels, or
12 how the education and outreach was going to be handled?

13 MS. BUDERI: The STCs contained some requirements
14 around minimum notices that need to go out. For example,
15 the state is required, by the STCs, to send out notices to
16 beneficiaries that are tailored to that beneficiary. They
17 need to say you're exempt for this reason, this is when
18 your exemption might end, under these circumstances, or
19 you're required to report activities, here are the
20 activities that qualify.

21 In terms of the kinds of outreach past that, I
22 don't believe the STCs require something like a beneficiary

1 relations contractor making a certain number of calls. So
2 you wouldn't know about any kind of supplemental outreach
3 strategy past those formal notices, I believe. And then
4 good cause exemptions, the STCs contain a minimum list of
5 good cause exemptions that the states need to provide. I
6 think it would be fair to say that Arkansas, you know, the
7 states have discretion to grant good cause exemptions for
8 reasons beyond the ones specified in the STCs. But the
9 STCs don't say, for example, that beneficiaries need to
10 know about the good cause exemption in the earlier notices.
11 It just says that they have to allow -- they have to
12 provide for a good cause exemption.

13 CHAIR THOMPSON: Yeah. I'm just trying to bring
14 home the point that to the extent that we want to weigh in
15 on or identify those areas, we're talking about a level of
16 operational detail that generally contained, if at all,
17 within protocols, that the state may develop, maybe with
18 approval of CMS or not. So it won't be clear, for example,
19 on some of the things, unless CMS decides that it wants to
20 make it clear, and that's, I think, a point of
21 conversation, on a group of waivers happening again in a
22 very contained period of time where there is a lot of

1 potential impact, that the level of detail around exactly
2 how things are going to be handled and who is going to see
3 a notice, at what point in time, and what is it going to
4 look like, and who are we going to engage to help us
5 educate beneficiaries, and all of those kinds of things,
6 that those decisions are generally made at the state, and
7 maybe without any kind of federal scrutiny.

8 And so what we should talk about, if we want to
9 get to that level, are we talking about, you know, again,
10 frameworks or rubrics or protocols, or is it transparency
11 for comment, or is it best practices, and, you know, those
12 kinds of things.

13 MS. BUDERI: Can I just clarify one point?
14 Arkansas did submit an eligibility and enrollment
15 monitoring protocol which does contain a lot of the
16 information that you're talking about, around, like, for
17 example, a lot of the stuff about AFMC is contained in that
18 protocol.

19 New Hampshire is also required to submit one of
20 those protocols and make that publicly available, but I
21 haven't seen that yet. It's not publicly available yet.
22 Earlier states with approvals, including Indiana and

1 Kentucky, when they were initially approved, did not have
2 that requirement to do a protocol like that and make it
3 publicly available. So I just want to make sure that you
4 have that information.

5 CHAIR THOMPSON: So there is, in fact, a
6 mechanism that CMS has used with Arkansas that contains
7 some of these details.

8 MS. BUDERI: Yes.

9 CHAIR THOMPSON: Okay. Good. All right.

10 COMMISSIONER MILLIGAN: Can I -- I'm sorry. I
11 won't take long this time. But I want quibble with just --
12 suggest an edit to one slide, Kacey, which is Slide 8, and
13 I think it kind of gets at some of this -- sorry, Anne. I
14 don't mean to accidentally read the materials.

15 I think it's more than a semantic thing. I just
16 want to kind of flag for you. The title is "Non-Compliance
17 among Beneficiaries without Exemptions." So in your first
18 bullet you talk about 91 percent of non-exempt
19 beneficiaries were non-compliant. We don't know if they're
20 non-exempt. We just know that they haven't reported an
21 exemption. And so, to me, this is where the good cause
22 issue plays in, is they might have an exemption but it

1 might just not be a reported exemption.

2 EXECUTIVE DIRECTOR SCHWARTZ: There's also a
3 difference here. There's a difference between being exempt
4 from the requirements and the good-cause exemption for
5 reporting, though. I just want to make sure we're not
6 mixing them up.

7 CHAIR THOMPSON: There are actually too many
8 versions of the word "exemption" in this program. But
9 because, you know, you're subject to the requirements you
10 are not subject to the requirements. If you are subject to
11 the requirements you may not need to report because the
12 state has found the information it needs. You may need to
13 report. If you don't report you may request a good cause
14 exemption. I mean, it's hard for us to understand.

15 And, you know, again, I think it becomes very
16 interesting to look at some of these data in terms of it's
17 not just, Chuck, that they may be exempt but didn't report
18 it. They may also be compliant but didn't report it. So
19 that's part of the distinction to make here about what do
20 we know about people in terms of their experiences. Are
21 they simply not reporting or are they, in fact, not meeting
22 the requirements? And if they don't meet the requirements

1 is it because, other than work, it's hard to cobble
2 together, for example, some of the things that you can use
3 to meet the requirements, in terms of education or
4 volunteer work, et cetera.

5 So, I mean, there's just a lot that we don't
6 know.

7 Let me ask Darin to weigh in, and then what I'm
8 going to do, we're going to go over time. We know this was
9 going to happen. I'm going to ask Darin to weigh in, and
10 then I have Kit, Sheldon, Kisha. But before you guys I'm
11 going to ask the public to jump in so that we give them an
12 opportunity.

13 All right. Darin.

14 COMMISSIONER GORDON: Just for fun I'd like for
15 you to go Slide 25 and then Slide 2, but I'm really just --
16 I'm not going to make you do that.

17 I agree with a lot of the comments Chuck has made
18 and Penny has made, and some of the points that Alan has
19 made. I think one of the underlying things -- and we tend
20 to see this far too often, actually, in Medicaid -- is the
21 unrealistic expectation on time frames from approval to
22 implementation. And so some of the things that are

1 following some of the gaps, whether it's around education,
2 outreach, data collection, processes put in place, is a
3 result of not ensuring that there's adequate time to put in
4 place these types of mechanisms that I think are necessary
5 with any kind of new program implementation. And I think
6 that's one of the things that we should consider weighing
7 with CMS, about ensuring that there's been thoughtful
8 consideration to what an adequate or appropriate
9 implementation time frame should be, given that they, at
10 the CMS level, will see how different states approach this
11 and will have some sense of what that time would be.

12 Secondly, you know, this population has
13 historically been difficult to outreach, and it's a
14 challenge on a lot of levels. It happens at
15 redetermination quite frequently. And I think given that
16 there has to be certain mechanisms in place for that
17 reality, there are things that you can do. Multiple
18 approaches to communicating is ideal, and having only one
19 way to report compliance through the portal. Again, there
20 are a lot of things Arkansas did, I think, that were
21 helpful and done well. Again, we have the benefit of
22 looking at it in hindsight and seeing some things that

1 could have been additive to improve how this has been
2 approaches. But multiple avenues by which to communicate
3 but also multiple avenues for which to report compliance I
4 think are necessary.

5 But regardless of how well you do there -- and
6 let's say Arkansas did a great job -- there's always going
7 to be situations where individual somehow did not get the
8 communication or did not have the avenue available to
9 report their compliance or why they should have an
10 exemption. And so there has to be a process for
11 individuals. And we've seen this in redetermination, where
12 they have the ability to come back and be able to provide
13 their proof or documentation of why they did, in fact,
14 comply or meet the expectations. And I don't know what
15 those processes are or if those were put in place but I
16 think that's something that needs to at least be considered
17 and thought through, because that is just the reality of
18 communication with this population.

19 I think a lot of the points around the good cause
20 that Chuck made were appropriate, and that was my point is
21 like how else are we communicating those things? How early
22 are we communicating those things? Again, some of that

1 wasn't included in some of the other notices. Some of it
2 is just, again, the rapid nature of a rollout of a complex
3 program.

4 The other thing that I think we should think
5 about in recommending to CMS is there are certain data
6 elements that I think are helpful in evaluating these
7 things, that should be some kind of baseline expectation
8 around certain data collection around this, so that, to
9 Alan's point, you would have the components with the
10 information that would, you know, support a more robust
11 research design. And often with these programs you have to
12 build those in on the front end and know what you're going
13 to collect in order to have that information later. It's
14 not something you can do retrospectively.

15 So making sure that, you know, thinking through,
16 looking at what we're learning from Arkansas, there are
17 questions you can't answer that I think the Commission
18 believes would be helpful in understanding a more complete
19 picture of what's going on. So that would be another
20 recommendation.

21 And then, you know, the point about strong
22 handoffs to the other resources, you know, just saying you

1 should go talk to this resource hasn't proven to be the
2 most effective way but it's something else that needs to be
3 thought through as other states are aligning. Again, it's
4 a lesson learned that CMS can help offer others.

5 The comment, you know, that Penny made early on
6 about the rapid cycle improvement, and, Alan, your point
7 about the robust research, I see those both being
8 necessary, because we have a tendency to wait too long to
9 extract learnings of new program implementations and hand
10 them off to other states who are contemplating these
11 things. And in some cases it's a, well, let's wait for the
12 more robust research design that's several years out, and
13 then you have a state at the starting gate and proceeding
14 down a path that could have benefitted from some of the
15 wisdom of those who had gone before them, about how to
16 avoid other pitfalls.

17 So I think that is a good role that CMS could
18 play, and seeing what they're learning from some of these
19 earlier states, to make sure that those components, whether
20 through STCs or in what form or fashion, that they're
21 ensuring that there is that exchange of the lessons learned
22 so as to avoid missteps that could have been prevented in

1 the very beginning.

2 CHAIR THOMPSON: Okay. Let me take a pause here
3 and then invite the public to come up for any commentary
4 that we could take into consideration as we continue and
5 then complete our conversations on this subject.

6 ### PUBLIC COMMENT

7 * MS. KRESS: Hi. I'm Marielle Kress from the
8 American Academy of Pediatrics.

9 First of all, thank you for spending this much
10 time on this issue. I completely agree that this is not a
11 one-state issue. This is clearly going to be a precedent-
12 setting policy that obviously many states are going to be
13 taking up and not just in expansion states but in non-
14 expansion states where parents at extremely low levels of
15 poverty are going to be subject to these requirements. And
16 pediatricians are quite concerned about that and the
17 effects that that will have on children. I think that's
18 the first point I want to make.

19 The slide says the state is not collecting data
20 on downstream effects of coverage losses. I think we have
21 very good data to show that when parents have coverage,
22 children are more likely to have coverage. And so I think

1 we should maybe take a look at what's happening to
2 children. I think we also have data on the facts that if
3 parents have coverage, children are also more likely to get
4 well child visits, so it's not just coverage. It's care.
5 So I would encourage MACPAC to look at the impacts of the
6 other populations in the Medicaid program.

7 And then the other thing I just wanted to say is
8 that I think MACPAC has a really unique role and voice on
9 the Hill, and I know that folks and staffers on both sides
10 of the aisle use your data and your analysis, and it cuts
11 through so much of the other information that they're
12 bombarded with. So we may have an opportunity for
13 oversight in the next Congress, and having your voice out
14 there to provide that information and that analysis to the
15 Hill, I think is invaluable. So I would encourage you to
16 do so.

17 Thank you.

18 CHAIR THOMPSON: Thank you, Marielle.

19 Kelly.

20 MS. WHITENER: Hello. Kelly Whitener with
21 Georgetown Center for Children and Families.

22 I haven't seen you guys since the CHIP debate,

1 but it's nice to be back. And I want to echo what Marielle
2 said about just really appreciating the time and attention
3 you're putting into this matter. It's obviously really
4 complex.

5 I want to kind of echo some of the comments made
6 by the Commissioners that the evaluation component and the
7 fact that there isn't one is very alarming in this process,
8 and yet the data that has come out so far is painting a
9 pretty clear picture of what's happening with over 8,400
10 people using coverage and expecting to continue to see
11 about 4,000 people losing coverage every month. It's kind
12 of clear what's going on.

13 If you start to parse through some of the data
14 that has been posted, you can see that the number of people
15 actually coming through the portal and reporting something
16 amounts to about less than 1 percent. Between the
17 automated exemptions and all the different types of exempt
18 ways, you're really not seeing a lot of new people showing
19 up to report new work. You're seeing kind of a duplication
20 of accounting, people that are already meeting a SNAP
21 benefit, but they're calling that new. So there's some
22 kind of funny business going on with those reports, and I

1 think it's important to take a close look at them.

2 Another point about those reports is that though
3 they are useful and voluntary, they are not posted to the
4 state website as far as I'm aware. They're distributed to
5 a small group of people.

6 We've been posting them to our website because we
7 think it's important for people to be able to access that
8 information, but it's not actually as transparent as it
9 should be. And I think CMS is doing a disservice to the
10 public by not requiring a robust evaluation up front and
11 more robust data along the way that is publicly available
12 and more to just a select group.

13 Then I also want to echo what Marielle said about
14 the application of these work requirements potentially to
15 very low-income parents and the pipeline CMS has before
16 them, a number of requests looking to expand work
17 requirements -- or looking to impose work requirements
18 since states that have not expanded and are not considering
19 expansion as part of that debate. So you have states like
20 Alabama and Mississippi where the coverage eligibility
21 levels are very low and wanting to expand a work
22 requirement there, which would be very damaging to children

1 and families, far beyond what we've even seen so far in
2 Arkansas.

3 So I just really encourage you to think about the
4 platform that you have and the ability that you have to
5 weigh in to both the administration and the Hill and to
6 have your voices be heard and not to let that pass you by.

7 * CHAIR THOMPSON: Okay. Let me return back to the
8 Commissioners, then, and pick it back up with Kit, Kisha,
9 and Sheldon, and then I'd like to check in and see if
10 there's anybody else, maybe, Alan, come back to you because
11 you said you wanted to hear. I'm going to put you on the
12 spot and give you advance notice because you said you
13 wanted to hear before you -- and then maybe suggest a path
14 forward in terms of the immediate and the longer term.

15 So, Kit.

16 COMMISSIONER GORTON: So I agree with an awful
17 lot of what's been said, and I won't reiterate. I think my
18 head is most closely aligned with where Chuck was coming
19 from and with some of what Darin said.

20 I want to start by saying that I have great
21 sympathy for Arkansas because I was on the front lines of
22 managed care rolling out in Pennsylvania, and we were told

1 there would be blood in the streets of Philadelphia. So I
2 get that this high-scrutiny period that you're talking
3 about is painful for them. That doesn't mean that they
4 shouldn't do their demonstration.

5 But they should do it well, and they should think
6 about decisions that they've made that add risk, perhaps
7 unnecessarily, to the program.

8 The single communication channel adds risk. The
9 lock-out adds risk, and I'm not saying that you wouldn't
10 grow into the lock-out at some point. But often as we've
11 rolled out these big program changes over the years, we've
12 sort of baby-stepped our way into it, and this one seems to
13 have been born fully formed from the head of Zeus and in a
14 very, very, very short time frame.

15 So I do think that there are things that have
16 been added to this program decision that increase risk and
17 which put Arkansas in the hot seat, which might have been
18 avoided and should be thought about both by Arkansas and by
19 other states who are moving down this path.

20 And I would underscore what Darin says about
21 don't go too fast. Everybody always tries to go too fast.
22 It gets in the way. Roll these things out gradually and

1 pay attention.

2 I do want to absolutely align myself with
3 something that Alan said, which is, Where is the program
4 evaluation plan?

5 And that brings me to the point that I really
6 want to make, and I do think that we should write to the
7 Secretary. And I think we should write to the Secretary,
8 and we should say, "Why the heck did this thing go live
9 without an evaluation plan? Why are these things not in
10 place? Why is the data not being collected as a baseline?"

11 We'll see what happens here, but I think the
12 idea, which I personally think is worth exploring -- I get
13 that there's not any evidence out there, but it's worth
14 thinking about, something that's front-of-mind for an awful
15 lot of people: Shouldn't people on Medicaid have to work,
16 make a contribution to their communities?

17 So let's explore it, but let's explore it
18 properly, which means collect baseline data, set up
19 comparison groups, get your evaluation criteria, hire your
20 vendor, do these things, and then turn the switch.

21 So I think CMS had an opportunity that they
22 missed, but they should rethink it in terms of what they

1 put in place before they let folks go live. I agree with
2 Penny's description of the sort of incremental roll-out of
3 STCs over time, and I don't think that CMS should sort of
4 smother these things in the cradle and not let people come
5 and experiment and test things out. But I do think that --
6 and I've said this before; others have said this before --
7 one of the failures of the 1115 process is that too often,
8 we get 5, 10, 15 years into it, and we still don't have any
9 data about whether the fundamental premise works or doesn't
10 work, and I don't think we should do that here.

11 So my point of view would be we should say to the
12 Secretary or to the Administrator, to whoever this is
13 properly addressed to, "Time out." This is a very
14 important topic. It's a front-of-mind for an awful lot of
15 people. Let's do it right, and let's hit the pause button,
16 not forever and not in response to what we're seeing in
17 Arkansas, but simply because we're not ready to dance here.
18 So that would be my perspective with many of the comments
19 that other people have made.

20 Implementations are always ugly. They're always
21 less ugly if you take a little more time and if there's
22 more data.

1 I guess one other thing I would say to CMS --
2 and, again, thank you to Arkansas for being as transparent
3 as they're being, and I hear the comment from the public
4 about it can always be more transparent. It can always be
5 more transparent, but there are reasons why it isn't, and
6 so I appreciate the transparency that Arkansas has brought
7 to the process so far.

8 I personally would feel better -- not if we saw
9 more reporting, but if we had some level of confidence that
10 CMS was seeing some reporting. I'm glad that CMS is
11 talking to the state, and I'm hopeful that they're talking
12 about substantive things. But it would be more helpful to
13 me, even if you can't produce high-quality reporting
14 because it doesn't meet the standards of public reporting,
15 blah-blah-blah, that we all know about, but can you at
16 least tell me what you're talking about? Yeah, we get
17 this. We understand that if our whole communication path
18 is based on sending people written notices and we have a
19 bad address, that, in fact, we have no communication path,
20 and we're going to figure out what we're going to do about
21 that.

22 So it would be useful for CMS to say -- and this

1 is my final comment. The issue here to me is less one of
2 an accelerated program implementation and more one, which I
3 think is germane to this Commission's role, of is effective
4 oversight in place, and my crisis of confidence here is
5 not that Arkansas won't take care of its people as best it
6 can, because I believe that. But I do worry that CMS does
7 not have its head in a place and the resources arrayed to
8 oversee this kind of demonstration and certainly not on a
9 broad scale across the country, and I think the Commission
10 is entitled to reassurances that they're thinking about
11 that.

12 CHAIR THOMPSON: Thank you, Kit.

13 Kisha and then Sheldon.

14 COMMISSIONER DAVIS: Thank you.

15 I think I can be brief and concise because of
16 many of the comments that have already been said.

17 I want to echo a lot of what Kit has been saying
18 about I do think it's our place to write a letter to the
19 Secretary of HHS to really talk about where are the lapses
20 in evaluation and why wasn't that done from the beginning
21 and how can we back-roll some of that and is it necessary
22 to slow down or pause or implement some of these things to

1 look at the program and where the lapses were.

2 I'm especially concerned about, in doing some
3 sort of evaluation, looking at what are the downstream
4 effects, so what's happening to these people that are
5 disenrolled, what are their health care costs now, are
6 their uncompensated care costs going up in the state
7 because of these folks that are now being kicked off the
8 roles, also thinking about is it actually increasing work.

9 I mean, there's no data that's actually looking
10 at is this having an effect on people working in the state,
11 and so if that underlying hypothesis is that this is going
12 to encourage more people to work, are we actually looking
13 at that and seeing if there's any outcomes around that?

14 Then the last thing is looking at reenrollment
15 cost. For these folks who have been disenrolled and then
16 now the following year after the lockout period are able to
17 reenroll, are their costs now higher because they've
18 delayed care for X amount of time? And so what does that
19 look like for those enrollees?

20 CHAIR THOMPSON: Sheldon.

21 COMMISSIONER RETCHIN: Thanks.

22 I will be brief, but I refuse to be concise. I'm

1 just not going to do it.

2 [Laughter.]

3 COMMISSIONER RETCHIN: I share everyone's view
4 about the work requirements, and we have now 25 years of
5 experience.

6 That said, I understand that some states are
7 interested in work requirements for Medicaid eligibility;
8 however, I am uncomfortable being held hostage on the
9 expansion idea since there are so many non-expansion states
10 now standing in line for similar waivers. The
11 administration has signaled that there's an interest in
12 that.

13 So I do think that they should be evaluated, and
14 I don't rule out the idea. However, in that regard, I'd
15 like to know what the hypothesis is. Is the hypothesis
16 that work requirements lead to higher employment rates,
17 which the Heritage Foundation has said absolutely not, that
18 it doesn't work, or is it to disenroll recalcitrant, non-
19 exempt eligibles? So I think that may be cynical, but it's
20 important to tease out and does need to be evaluated.

21 But I really get down to the role idea of the
22 outreach, which there's a couple of things to make a point

1 on this.

2 First of all, Arkansas is the eleventh worst
3 state in terms of internet access, and many of the states
4 that are in line for work requirements and major policy
5 changes have very bad internet access. Still, a third of
6 Arkansans and 25 percent of Americans do not have internet
7 access at home. So that restriction alone to me is the
8 pause button.

9 But I am reminded of another major policy rollout
10 where there was major criticism and disruption over the
11 ability to contact potential eligibles, and that was the
12 marketplace exchanges. Man, there were congressional
13 testimonies. People's careers were put on the line, and it
14 was all over the rollout. As a result, there are today
15 five different methods that someone can access the
16 marketplace exchanges.

17 Restricting this portal to only online access, I
18 think is fundamentally flawed and will be in states that
19 are dominantly rural. I think that alone to me is worthy
20 of a pause.

21 CHAIR THOMPSON: Okay. Alan, I am going to
22 circle back with you, give you one more chance, and then

1 I'm going to try to make a proposal.

2 COMMISSIONER WEIL: My only direct reaction is
3 I'm certainly aware of the politics of the tie between work
4 requirements and expansion or retention of an expansion.

5 I'll just say what's often been said about the
6 Medicaid program, which is if you want to do something
7 that's not in the statute, change the statute. It's been
8 done quite a few times. So I don't want to just use the
9 politics to sort of release any tie to the statute.

10 What I'm hearing is a lot of concern about the
11 operational side, which was not really the focus of my
12 comments. You asked me to re-reflect, and what I would say
13 is I do think I'll stand by what I said earlier, which is I
14 would call a pause on new states. I really would, but I
15 think our legislative charter is to make recommendations to
16 the Secretary and the states.

17 Based on what I'm hearing here, I would say that
18 we have significant concerns about whether or not the
19 hypothesis is clearly stated and whether or not we'll learn
20 from it. That feels pretty abstract to me. I mean, I have
21 to say these are people's lives, and this whole
22 conversation has felt very abstract. But when I listen to

1 colleagues, what I hear is agreement on concern about
2 whether or not we'll learn and not so much agreement on
3 concern about what's happening so far, other than as an
4 operational challenge.

5 I would say we ought to say to the Secretary and
6 to the state that while we appreciate the transparency that
7 has occurred thus far, we're very concerned that given what
8 we've seen, it's not going to be clear whether or not the
9 premise of this policy is accurate. Maybe in our next
10 meeting, we'll say something stronger than that, but that
11 would feel to me like a start.

12 CHAIR THOMPSON: Stacey.

13 VICE CHAIR LAMPKIN: Well, I just wanted to say
14 maybe part of it, even if our comments are operational and
15 around about -- they're set up by saying this is not just
16 any kind of policy area. This is a policy area with
17 significant implications on people's lives and health, and
18 it's in the setup of the argument that we can make the case
19 that these are people's lives, really.

20 CHAIR THOMPSON: Melanie.

21 COMMISSIONER BELLA: Sorry. It's just the deja
22 vu. I can't help but say because this feels somewhat like

1 duals demo. It's different, but it's a complex program.
2 It's hard to understand, and there's criticism of it going
3 too fast. So I just have to comment.

4 I think it's important for us to consider pause
5 on the new states. I also think it's important for us to
6 consider pause here.

7 I can only go on the demonstrations, but when
8 there were problems, we stopped enrolling people in a
9 particular state. Just like here, you would stop until you
10 got something fixed, and there was a very prescriptive
11 process on the front end of readiness review of a state to
12 do something new, which is in line with kind of more of the
13 operational, but also sort of the evaluative piece.

14 So I think as we consider pause, I would just
15 encourage us not to think about pause future, but think
16 about pause of what's in front of us. Whether it's duals
17 demos or other things, there's precedent, certainly
18 precedent for doing that from the agency's perspective,
19 while respecting the state.

20 CHAIR THOMPSON: Yeah. It does happen on a rare
21 basis and much easier to pause moving forward than to
22 pause ongoing.

1 So this is what I would like to suggest, based on
2 what we're hearing. It sounds like, first of all -- and
3 I'm going to highlight a couple of places where maybe we
4 have a disagreement or maybe we have different views, and I
5 want to tease that out, give everybody one more time to
6 tease those points out.

7 So I think it's clear we want to write to the
8 Secretary. We want to express concerns about the early
9 returns from Arkansas. We want to point to this being not
10 just about Arkansas. If Arkansas was the only state in the
11 nation that was doing this for the next five years, it
12 probably wouldn't have merited the amount of time and
13 attention that we're giving to it at the last meeting and
14 this meeting. So it is the fact that it's an early return
15 on a program feature of significance with big impacts on
16 beneficiaries, where we will have potentially a fair number
17 of states wanting to move forward in various ways, and so
18 it becomes really important to try to extract every bit of
19 lessons and early indication that we can from the state
20 that has gone live.

21 We have a bunch of things that I think we don't
22 need to repeat about observations on kind of the process

1 and places where we think maybe more attention needs to be
2 paid and more opportunity exists for improvement. We have
3 some general observations about giving things enough time,
4 thinking about phasing, reducing the risk associated with a
5 new program feature on populations that could help ensure
6 smooth operations and improve the overall objectives of the
7 program.

8 There are some Commissioners who may question the
9 underlying hypothesis, but even taking the underlying
10 hypothesis as the approved basis of the waiver, we are
11 concerned, as we have been for some time, about monitoring
12 evaluation of 1115 waivers that were not getting the right
13 kind of demonstration setup and research framework and
14 baseline data and agreement on measures that will set us up
15 for success in terms of understanding whether our
16 hypothesis is correct and doing so in a way that is robust
17 and timely.

18 That does not mean, I don't think -- but this is
19 Penny in a parenthesis here -- I don't think that means
20 that we need everything -- the contract, the scope, the
21 measures -- everything set up in advance, but I do think
22 you need enough set up in advance so that you can

1 successfully evaluate. So in sort of the same way that,
2 Chuck, you were saying about beneficiaries need to be set
3 up to succeed. The research hypothesis, the evaluation
4 framework, and the methodology needs to be set up to be
5 able to provide timely input. I think that's all
6 reflective of a fairly broad consensus among the
7 Commissioners about what we would say in this letter to the
8 Secretary.

9 Here's maybe two places where I heard maybe some
10 differences. One is pausing. So I invite some more
11 commentary on this, which is the way that I would put it is
12 all of this means it may take more time to approved a
13 waiver or to go live on a waiver, and we think that time is
14 worth it. How much time that takes, how it applies to a
15 specific state that may be having submitted a waiver -- in
16 other words, I'm concerned pausing suggests everything
17 stops until everything is figured out, and I don't know
18 that we're ready to say that on the basis of one state with
19 a particular approach and early results.

20 And so I think I would be more comfortable with a
21 statement that says we just think the investment in
22 thinking through these things and addressing some of these

1 issues is worth the time that it may take. It will pay off
2 in the end. The question of how much time is that and what
3 do you really need to do and how much of this could be
4 ready or is ready is something that the Secretary should
5 think about.

6 So that's one point I want to invite some more
7 commentary on. That obviously means we're not making a
8 particular commentary on Arkansas per se, in terms of
9 whether -- I mean, we can point out that we believe that
10 Arkansas should also think about these kinds of things, but
11 that relates to the second point where we may have some
12 difference, which is I would not suggest that we're writing
13 to Arkansas. Now we have a mandate where we make
14 recommendations to states that could be seen as inclusive
15 of recommendations to a state. We would certainly share
16 this conversation and the letter with Arkansas. But to me
17 the primary audience for our comments at this time would be
18 the Secretary.

19 So let me just open those two points up, and any
20 other others that folks think want to tweak a point that I
21 said. Kisha and then Martha and then Fred.

22 COMMISSIONER DAVIS: I think, to your first

1 point, about the overall pause in the program I definitely
2 agree with that. I do think that there is a place, though,
3 to say -- and maybe it's to Arkansas or maybe it's to CMS -
4 - that maybe disenrollments need to be paused until they
5 can work out some of the operational issues around access
6 and portals and mailings and all of that, and is there some
7 slowdown that needs to happen there before another 4,000 or
8 12,000 are kicked off the rolls.

9 CHAIR THOMPSON: Okay. Martha.

10 COMMISSIONER CARTER: I'm going to add a little
11 anecdotal information. The community health centers, to
12 your point, Sheldon, have outreach enrollment specialists
13 to help people with the Marketplace, and they also help
14 with lots of other program eligibility. So I reached out
15 to a colleague in Arkansas who coordinates the state-reach
16 outreach and enrollment folks. And what they're hearing is
17 that people just don't know that they were eligible or they
18 had a requirement. And the health centers provide care for
19 75,000 non-CHIP Medicaid people in Arkansas.

20 So I'm not sure to the extent that the health
21 center outreach and enrollment people were involved in this
22 process but I'm coming down on the side of pausing the

1 disenrollment so that there's more time for the state to
2 improve their processes around reaching this population
3 that's very difficult to reach, and then including that
4 requirement in the upcoming applications, waivers.

5 CHAIR THOMPSON: Melanie, and then -- I'm sorry,
6 Fred, I skipped over you, so go Fred first, then Melanie.

7 COMMISSIONER CERISE: I just would -- I'm aligned
8 100 percent with Alan on if this is a demonstration and you
9 don't have a way to demonstrate what you're doing, I would
10 encourage no more of these until you have a solid
11 demonstration plan. But also change the statute, like you
12 said, and say that's not what we're going to do, but do one
13 of the other. I would not focus so much on the technical
14 issues surrounding -- I mean, I know those are real issues
15 but I think there's a bigger fundamental question here.

16 CHAIR THOMPSON: Melanie.

17 COMMISSIONER BELLA: Yeah, I agree there is a
18 bigger fundamental question but there are a lot of people
19 like right in front of us that are losing coverage. And so
20 I guess I don't mean we should stop working on these
21 things, right, but there's a way to make them stronger and
22 there's sort of a continuum of things that could be done to

1 do that. It's unfortunate that there wasn't more rigor on
2 the front end, to make sure that these systems were in
3 place and beneficiary notices had been tested and all these
4 things, but it didn't happen that way.

5 And so this just feels a lot different to me,
6 that it's not like we're moving someone into managed care
7 and they might lose access to doctors. We're taking them
8 off the program. And so I don't think we should take
9 pausing the disenrollment in Arkansas off the table. Or if
10 we don't want to pause the disenrollment maybe we say
11 please get an ombudsman in place, you know, there's other
12 things. Reduce the lockout period. I mean, they've gone
13 to such an extreme here, you're off for the whole rest of
14 the year.

15 And so there's different things. I think if we
16 don't want to go all the way on pausing on disenrollment
17 put something in there that requires making sure
18 beneficiaries understand this better and maybe not make the
19 consequences so harsh until we're sure that some of the
20 other processes are in place.

21 I realize this is states' rights. I get it.
22 Like I don't like to trample on states' rights either. I

1 like Chuck's lens about make people successful within the
2 rules that the state has chosen. And if we could do that -
3 - I just think we didn't have enough enforcement of any
4 sort of standardized set of expectations on the front end
5 to make sure that the rules the state chose were ones that
6 people could succeed it.

7 CHAIR THOMPSON: Chuck, did you want to respond?
8 Okay. So let me do Kathy, Toby, then Chuck.

9 COMMISSIONER WENO: I just wanted to add my voice
10 to the pause contingent of the group. I would say, you
11 know, as a former legal aid attorney, this whole loss of
12 coverage is really concerning to me, and I also would say,
13 you know, I do want to give credit to Arkansas. It sounded
14 like they did do a considerable outreach effort. I mean,
15 it just didn't work that well.

16 So I think we need to, you know, evaluate that,
17 try and figure out a better way to do outreach to this
18 population, but then also looking at the other states that
19 are in line for that, so they can also address that issue
20 before they try and try it.

21 CHAIR THOMPSON: Toby.

22 COMMISSIONER DOUGLAS: So first I struggle

1 considerably with the idea of us getting involved in
2 states. These are a lot of state policies that the balance
3 between the overall goal, whether it's expansion, whether
4 it's how to continue benefits or ways of moving fast at
5 managed care, there are multiple times this occurs. But
6 there's this balance here, as well as doing it right and
7 figuring out how to continuously operate and improve, and
8 as Melanie said, the duals are many times experiences of
9 continuously improving and changing the process and pausing
10 and changing.

11 And so that's what we have here, and I struggle
12 to see how we can pause on future when we have one right in
13 front of us that is still fundamentally going to set the
14 framework, and yet right now we're seeing no ability to
15 evaluate. And so why not pause that too, work on ways to
16 continuously improve the process of outreach engagement,
17 all the different structures within it, as Chuck said on
18 processes, and then we can evaluate all these in a way that
19 tests the hypothesis.

20 CHAIR THOMPSON: Chuck.

21 COMMISSIONER MILLIGAN: I just want to align
22 myself with the notion of a pause too. I just want to make

1 sure that we were clear what we're going to recommend
2 pausing. I do think, for the ones in the pipeline, the
3 pause would take the form of don't approve it until there's
4 a research design and evaluation method. And so there's a
5 pause for the stuff in the pipeline.

6 I think with respect to some of the discussion
7 about the pause, with the recommendation with Arkansas
8 about disenrollments being paused until some of the other
9 kind of infrastructure catches up, I'm supportive of that
10 as well. So I just wanted to align to some of the comments
11 I've heard.

12 CHAIR THOMPSON: Okay. So it does sound like we
13 have actually a view that HHS should take the time before
14 approving additional waivers, that it establish the
15 evaluation framework, that there be some early data
16 collection, that they examine and discuss some of these
17 dimensions of operational performance that we've seen, some
18 good, some maybe could be better, based on Arkansas, and
19 that they work with Arkansas to pause the process to avoid
20 harm to beneficiaries while adjustments are made inside of
21 that waiver with regard to either reducing the penalty
22 associated with reporting or doing some follow-up to ensure

1 that the people who are not reporting are not reporting
2 because of barriers to reporting, and providing some
3 additional information to CMS about those beneficiaries and
4 those processes.

5 Okay. All right. So let me see if anybody has
6 any additional thoughts at this junction. We did go a
7 little over time. Let me ask the public for comment.

8 [No response.]

9 CHAIR THOMPSON: Okay. Great. Since we are
10 behind let me just make an adjustment to the afternoon
11 schedule, because we're not going to start again in 20
12 minutes. We will give ourselves until 1:30. Will that be
13 enough time for lunch? All right. Why don't we give
14 ourselves until 1:30. We'll pick back up then. For now we
15 are adjourned.

16 * [Whereupon, at 12:55 p.m., the meeting was
17 recessed, to reconvene at 1:30 p.m. this same day.]

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1 **### PROPOSED PUBLIC CHARGE RULE: EFFECTS ON MEDICAID**
2 **AND CHIP**

3 * MS. HEBERLEIN: Thank you. So on October 10,
4 2018, the U.S. Department of Homeland Security issued a
5 proposed rule that would change the definition of public
6 charge for purposes of immigration status. While the
7 proposed rule, as Penny said, does not make changes to the
8 Medicaid regulations, the changes that it does make are
9 likely to have implications for beneficiaries, providers,
10 and states nonetheless. So we'll spend the next session
11 discussing the rule and the potential implications for
12 Medicaid. I will begin today by discussing immigrant
13 eligibility for Medicaid before providing some background
14 on public charge, the proposed changes in the rule, as well
15 as the potential effect they might have on Medicaid. And
16 then I will discuss potential areas for you all to comment
17 if you choose.

18 So, to begin, in order to qualify for the full
19 range of benefits offered under Medicaid, individuals must
20 be citizens or nationals of the United States or qualified
21 aliens. The term "qualified alien" was created by the
22 Personal Responsibility and Work Opportunity Reconciliation

1 Act of 1996, also referred to as "welfare reform." It
2 includes lawful permanent residents, refugees, and asylees,
3 among others.

4 Lawful permanent residents entering the U.S.
5 after August 22, 1996, are generally barred from receiving
6 full Medicaid benefits for five years, after which coverage
7 becomes a state option, and this is an option that most
8 states have adopted.

9 Children and pregnant women who are lawfully
10 present may be covered during the five-year bar, also at
11 state option, and as of January 2018, 33 states had adopted
12 the option for children and 25 had adopted the option for
13 pregnant women.

14 Non-qualified aliens as well as qualified aliens
15 who are subject to the five-year bar who meet income and
16 other eligibility criteria for the program can only receive
17 limited emergency Medicaid coverage.

18 So the Immigration and Nationality Act requires
19 that an individual seeking admission to the United States
20 or seeking to change his or her status to lawful permanent
21 resident is not admissible if at the time of application
22 for admission or adjustment is likely at any time to become

1 a public charge. Not all applicants are subject to a
2 public charge determination. For example, lawful permanent
3 residents who already have their green cards and are
4 seeking citizenship as well as refugees and asylees are
5 specifically exempted from the process.

6 Under policies that have been in effect since the
7 late 1990s, "public charge" has been interpreted to mean
8 that the individual is primarily dependent on the
9 government for subsistence. This is demonstrated by the
10 receipt of cash assistance or institutionalization for
11 long-term care at government expense. Short-term
12 institutionalizations for rehabilitation and current or
13 past receipt of non-cash benefits are not taken into
14 account. So non-cash benefits, which include Medicaid and
15 CHIP, are considered to be supplemental and do not make a
16 person primarily dependent on the government for
17 subsistence. And then inadmissibility is determined based
18 on the totality of an individual's circumstances.

19 So as I mentioned, earlier this month the
20 Department of Homeland Security issued a proposed rule that
21 would change the definition of "public charge" for purposes
22 of immigration status from what is currently in effect.

1 Specifically, the proposed rule would change the definition
2 of who may be considered a public charge from someone who
3 is primarily dependent on public benefits to someone who
4 receives one or more public benefits. Public charge
5 determinations would continue to examine just the
6 individual and not take into account benefits received by
7 family members, and this is a change from an earlier draft
8 of the proposed rule.

9 In addition, the proposed rule would expand the
10 list of public benefits that can be considered in a
11 determination of public charge to include Medicaid.
12 Receipt of Medicaid would be considered a public benefit
13 under the proposed rule if an individual received Medicaid
14 for more than 12 months within a 36-month period or
15 received Medicaid for more than nine months if the
16 individual also received a so-called monetized benefit such
17 as cash assistance.

18 Certain benefits, including emergency Medicaid,
19 school-based Medicaid services, Medicaid benefits provided
20 under the Individuals with Disabilities Education Act, or
21 IDEA, and Medicaid for certain children of citizens with
22 citizenship pending, such as foreign adoptees, would be

1 excluded from the public charge determination.

2 CHIP is not included in the proposed list of
3 public benefits, but the department is seeking comments on
4 whether or not it should be.

5 Consistent with the earlier guidance, the
6 department will continue to consider institutionalization
7 at government expense as a public benefit.

8 Under the proposed rule, immigration officials
9 would continue to consider the totality of an individual's
10 circumstances in making a public charge determination.
11 Under statute this must include the individual's age,
12 health, family status, assets, resources, education, and
13 skills. The proposed rule describes how these factors
14 would be considered and whether certain characteristics
15 would be considered positive factors that would decrease
16 the likelihood of becoming a public charge or negative
17 factors that would increase the likelihood of becoming a
18 public charge.

19 An assessment of the financial status of an
20 individual would also include consideration of whether he
21 or she has applied for or received Medicaid. In addition,
22 the proposed rules would weigh certain factors more heavily

1 than others. Among those heavily weighted negative factors
2 is current or past receipt of Medicaid within the last 36
3 months.

4 So moving on to implications, as discussed at the
5 beginning, the proposed rule does not change Medicaid, but
6 including Medicaid in the determination would have
7 implications for the program. So starting with the
8 beneficiaries, the proposed rule would likely have a direct
9 effect on individuals awaiting a decision on their
10 application to either enter or stay in the United States.
11 The DHS estimated that among those already present in the
12 U.S., 382,000 green card applicants and 517,000 applicants
13 for other types of visas would be subject to the new public
14 charge criteria annually.

15 It is unclear how many of these individuals would
16 be deemed inadmissible on public charge, but estimates
17 based on immigrant use of benefits suggest that the share
18 of non-citizens subject to a public benefit determination
19 would increase if the definition were enacted.

20 In addition, given the potential consequences for
21 the immigration status, individuals who are legally
22 entitled to coverage may choose to disenroll or not enroll

1 because of fear or confusion, a so-called chilling effect.
2 This hypothesis is supported by anecdotal evidence. For
3 example, there have been a number of recent news reports
4 that have noted the fear of public charge affecting take-up
5 among public programs. Also, in a recent study involving
6 interviews with families, immigrants have expressed fears
7 that participation in Medicaid or other programs could
8 jeopardize their immigration status.

9 The experience from welfare reform is also
10 illustrative. Following welfare reform in 1996, there was
11 a sharp decline in immigrant participation in public
12 benefits. The decline was due to the fact that the law
13 restricted eligibility among recent lawful permanent
14 residents, but the legislation also served as a deterrent
15 to enrollment for many immigrants who remained eligible but
16 did not apply out of fear for the negative immigration
17 consequences of being determined a public charge.

18 The confusion following the changes in welfare
19 reform resulted in some negative public health consequences
20 and led in part to the earlier guidance that I outlined
21 before.

22 A body a research shows that the declines in

1 enrollment in public benefits range from approximately 20
2 to 60 percent, depending upon the benefit that was looked
3 at. For example, one study found that the use of Medicaid
4 among non-citizen households fell by 22 percent between
5 1994 and 1997. Among non-citizens with income below 200
6 percent of the federal poverty level, participation in
7 Medicaid declined 19 percent during this time period.
8 Declines were also seen among populations that were not
9 subject to welfare reform, including citizen children of
10 non-citizens and refugees.

11 A recent study estimating the effects of the
12 proposed rule suggests that if disenrollment ranged between
13 15 and 35 percent, 2.1 million to 4.9 million Medicaid and
14 CHIP enrollees in families with at least one non-citizen
15 would disenroll. The chilling effect could also extend to
16 citizen children. In 2016, there were 10.4 million citizen
17 children with at least one non-citizen parent, and of
18 these, 5.8 million had Medicaid or CHIP. Assuming similar
19 disenrollment rates, an estimated 875,000 to 2 million
20 citizen children with a non-citizen parent could drop
21 coverage despite being legally eligible.

22 To the extent that the proposed rule creates a

1 barrier to coverage, it is likely to result in increases in
2 uncompensated care among providers such as hospitals,
3 community health centers, and other providers as they see
4 an increase in uninsured patients.

5 Furthermore, immigrants and their families may
6 forgo preventive or routine care, which could lead to an
7 increase in more costly services. The department
8 acknowledges that the rule could result in reduced revenues
9 for health care providers participating in Medicaid.

10 Implementation of the proposed rule could also
11 affect states. First, it is not clear how the department
12 plans to track individuals' use of public benefits, whether
13 it will be the responsibility of the various state benefit
14 agencies, and whether that information can be shared across
15 entities. The rule acknowledges that agencies may need to
16 make changes to forms, procedures, and systems, and seeks
17 comments on what might be necessary.

18 Second, states may find it necessary to take
19 other steps, for example, to conduct outreach activities,
20 change notices, and alter other procedures to advise
21 beneficiaries of the potential immigration consequences of
22 enrollment.

1 Finally, the decline in enrollment anticipated in
2 the proposed rule could have fiscal implications due to
3 loss of federal Medicaid funds and increased costs for
4 uncompensated care and other state services.

5 Finally, as I mentioned, the rule does not
6 currently include CHIP as a public benefit but seeks
7 comments on its inclusion. If CHIP were added, the
8 implications that I just went through for Medicaid, such as
9 the coverage losses and state and provider effects, would
10 likely be similar to those expected to occur with the
11 inclusion of Medicaid.

12 In addition, it may be worth noting that families
13 typically do not know whether their child is enrolled in
14 Medicaid or CHIP. As such, it may be possible that
15 enrollment in CHIP could be affected regardless of whether
16 or not the program is included as a public benefit.

17 Furthermore, as shown in this illustrative
18 figure, states have made different choices as to where to
19 set their Medicaid and CHIP eligibility thresholds. Here
20 the dark bars at the bottom represent Medicaid, the hashed
21 bars are Medicaid expansion CHIP, and the light blue bars
22 represent separate CHIP programs -- or maybe they're light

1 green. It's hard for me to tell.

2 Given the varying eligibility levels across the
3 states, the proposed rule could affect children at the same
4 income level differently depending upon where they reside.

5 So the proposed rule is open for comment until
6 December 10, 2018. The Commission may want to consider
7 commenting on the areas listed on this slide or other areas
8 of interest. If you should choose to comment on this
9 proposed rule, the comments as Penny said, would be
10 confined to issues affecting Medicaid and CHIP as within
11 our statutory purview.

12 As suggested from earlier experiences, the
13 proposed rule could create a barrier to access for those
14 who are otherwise legally entitled to coverage. The
15 Commission has voiced concern in the past regarding
16 policies that could lead to potential coverage losses, for
17 example, when you discussed reauthorization of CHIP
18 funding.

19 The Commission may also wish to highlight the
20 effects that a potential decline in enrollment could have
21 on providers and states, including a potential increase in
22 uncompensated care, a decline in federal Medicaid funds, or

1 potentially additional administrative expenses associated
2 with implementation. And as just discussed, the proposed
3 rule does not currently include CHIP, but the Commission
4 may wish to comment on the implications of its inclusion.

5 So with that, I will turn it over to you for
6 discussion.

7 CHAIR THOMPSON: Thank you so much. That was a
8 great summary, and I have a few questions and then want to
9 open it up for more conversation among the Commissioners.

10 I do think that our contribution here is in
11 helping the drafters understand Medicaid and CHIP. That to
12 me is the big contribution in terms of both as they look --
13 as they talk about Medicaid, understanding Medicaid in the
14 context of a state program with a lot of variations in how
15 it operates; as you mentioned, how states incorporate or
16 don't incorporate CHIP; if there are impacts that are
17 secondary to the primary purpose that have to do with, you
18 know, what's happening to the safety net system that we can
19 point out other impacts happening to the safety net system
20 that will potentially amplify those impacts. You know, we
21 had a discussion earlier today about DSH reductions and how
22 those are going to be distributed, and sort of pointing out

1 that those kinds of things are happening. So to the extent
2 that there may be impacts that increase uncompensated care,
3 it should be viewed not just in and of itself, but in the
4 context of these other activities.

5 A question that I had about something that I
6 don't think I saw in your slides but it was in the paper
7 about -- and this was a point of confusion that I had
8 initially -- about whether it's receiving benefits or
9 applying for benefits, can you just tease that out for us?
10 Because I think there's a different -- an additional set of
11 issues if there is an implication for people who are in the
12 process of applying.

13 MS. HEBERLEIN: I will do my best, because in my
14 read it is not completely clear how those things will all
15 fit together. So the definition of a public charge under
16 the new rule would be someone who receives one or more
17 public benefits. A public benefit includes Medicaid, which
18 is defined as receipt of Medicaid for 12 months of 36
19 months. And then further on, it describes how they will
20 weigh different factors in determining whether someone is a
21 public charge. And there they talk about financial self-
22 sufficiency, and they talk about Medicaid. And there they

1 talk about a negative factor will be whether or not
2 somebody has applied for or received Medicaid. So they
3 talk about it in multiple places --

4 CHAIR THOMPSON: Both ways.

5 MS. HEBERLEIN: -- and so how they all fit
6 together, it may be additive --

7 CHAIR THOMPSON: Okay. To the extent that we're
8 confused, we might want to point out we find it confusing.
9 But beyond that, I think the other thing that we can
10 contribute in terms of understanding the program is that
11 applying for health insurance subsidies is not -- people
12 come and apply for help. They don't necessarily come and
13 apply for Medicaid. So if you come to the federal exchange
14 as an example, you're getting assessed for all sources of
15 coverage and, depending on your state, you may get a
16 determination that you are eligible for Medicaid, whether
17 you thought you were asking for that or not.

18 So I think -- and, in fact, you know, of course,
19 the ACA laid out this idea of a seamless, integrated
20 eligibility process and system that was not program
21 specific. So that, of course, becomes even more important
22 to understand if you're trying to make distinctions, as the

1 drafters are, between exchange subsidies, CHIP, and
2 Medicaid when, in fact, those differences as they exist at
3 the state level may not be so clear and may be pretty messy
4 and those differences certainly in the application process
5 are not obvious or straightforward. So I think those are
6 points that I think can be really helpful.

7 And then, of course, from the standpoint of, you
8 know, a particular family in a particular state may be
9 getting help through subsidies versus Medicaid, depending
10 on whether the state expanded or Medicaid versus CHIP. So
11 I think helping the drafters understand the lines or the
12 messiness or the degree to which it varies by state I think
13 can help them take that into consideration.

14 With respect to the impact on providers and the
15 safety net, I think that we can point out it may be bigger
16 than they think, depending on the results of this -- you
17 know, what happens with this chilling effect. I'm a little
18 worried that it seems like our evidence for that is all
19 based on concerns expressed by others -- but I think we
20 should let them express those concerns for themselves -- or
21 kind of secondary research. So I would like maybe you to
22 help us see what we have originally to contribute about

1 being able to project potential impacts that maybe are
2 different than the drafters assumed on the basis of -- I
3 know Anne makes fun of me when I talk about modeling, just
4 meaning any kind of research or scientific analysis or
5 data-based analysis. You know, whether we have anything
6 that we could be doing there that really kind of
7 contributes a view of that that is different than others
8 are helpful.

9 So let me open it up for any other commentary,
10 additional commentary from the Commissioners. Kit.

11 COMMISSIONER GORTON: So I would just add to your
12 list, when you were talking about, you know, any open door,
13 in some states having insurance is still mandatory,
14 Massachusetts being among them.

15 CHAIR THOMPSON: Yep.

16 COMMISSIONER GORTON: So it's not optional for
17 people. So I think that's worth -- and the other question
18 that came to me as I was reading through this is: What
19 about HIPAA? This is protected information. Your
20 insurance coverage is protected. We don't disclose to
21 people whose members of what or whatever else. So wouldn't
22 we have to give DHS authority to draw down, particularly in

1 these circumstances where not everybody has -- no? Am I
2 completely off --

3 CHAIR THOMPSON: I think we're just all
4 quizzically wondering whether that's true or not true.

5 COMMISSIONER GORTON: It's not public information
6 whether --

7 CHAIR THOMPSON: But government agencies exchange
8 data all the time. But that's -- I mean, we can take a
9 note.

10 COMMISSIONER GORTON: I was just asking a
11 question. I don't know what the answer is.

12 MS. HEBERLEIN: So it's my understanding that the
13 rules of data sharing are different depending upon the
14 public program, and I think for like TANF, the state
15 agencies can share what they know about immigration status.
16 In the ACA there was some pretty clear rules that when
17 you're applying for coverage, that information is only to
18 be used for applying for coverage and not to be used for
19 other purposes. And there was some guidance that came out
20 that was talking about immigration being one of those
21 purposes. So --

22 CHAIR THOMPSON: So how do the drafters respond -

1 - you know, handle that? Or did they know about that?

2 MS. HEBERLEIN: I don't know if they know about
3 that or not. They don't really talk about how they will
4 track whether or not somebody has used a public benefit,
5 and so that's one of the questions, I think, that is sort
6 of outstanding.

7 CHAIR THOMPSON: All right. Well, that is an
8 example of, I think, applying some expertise -- thank you,
9 Kit -- to contribute some considerations.

10 Toby and then Alan.

11 COMMISSIONER DOUGLAS: So agree that we should
12 lay out some of the impacts that you put in here. I have
13 more of a technical question around the exclusions for
14 school-based Medicaid services as well as Medicaid benefits
15 provided under the Individuals with Disabilities Education
16 Act. I'm struggling how that's possible given that they're
17 going to be -- the way the schools get -- you get what I --
18 so if you can just answer that.

19 [Laughter.]

20 MS. HEBERLEIN: Yes, I was totally following
21 where you were going.

22 COMMISSIONER DOUGLAS: Okay.

1 MS. HEBERLEIN: So, yes, in order to be
2 reimbursed for services provided in a school, a child would
3 need to be Medicaid enrolled, and the school would need to
4 be a Medicaid provider.

5 IDEA services are slightly different. If the
6 child is Medicaid enrolled and the family gives them
7 permission to bill, then they can -- I'm looking at Joanne
8 because we talked about this -- then they can get Medicaid
9 funds for those IDEA services. If not, states do --

10 COMMISSIONER DOUGLAS: But they still have to be
11 on Medicaid.

12 MS. HEBERLEIN: Yes, and states -- but states do
13 have some limited IDEA grant funds that they could use to
14 provide some of those services if the child is not Medicaid
15 enrolled or if the child's parent doesn't give them
16 permission to bill Medicaid for those services.

17 COMMISSIONER DOUGLAS: But now --

18 CHAIR THOMPSON: But you're making --

19 COMMISSIONER DOUGLAS: Both of those just should
20 be -- they don't make sense. I mean, you can't do it.

21 [Laughter.]

22 COMMISSIONER DOUGLAS: They're putting in an

1 exemption that doesn't even exist.

2 CHAIR THOMPSON: Right. So, Toby, you're saying
3 it's defined as a Medicaid service, but Medicaid services
4 are only available to Medicaid enrollees.

5 COMMISSIONER DOUGLAS: And once they're on
6 Medicaid, then all the other doctors are going to play into
7 account. They can't go --

8 CHAIR THOMPSON: Right, so how is the state --
9 even if a state and a beneficiary were trying to work
10 together to segment those services, how would they be
11 segmented --

12 COMMISSIONER DOUGLAS: Because there would still
13 be a capitated payment going to the managed care plan, so
14 there would be -- they would be a public charge under this
15 definition for other reasons.

16 CHAIR THOMPSON: Okay, yeah. So I think the --
17 that's a good point. The viability of making some of the
18 distinctions in the context of how Medicaid pays for and
19 delivers services is, you know, more challenging and
20 potentially problematic than perhaps they understand.
21 Emergency Medicaid, though, is a little bit different,
22 right? Because that is really handled separately, right?

1 Okay. So we should maybe -- if we see some, like that
2 could work, but this is not going to be -- you know, would
3 require a complete redesign of something.

4 Alan?

5 COMMISSIONER WEIL: Just to add to Toby's
6 absurdity, does that mean if you --

7 COMMISSIONER DOUGLAS: I didn't say that.

8 [Laughter.]

9 COMMISSIONER WEIL: To the absurdity that Toby
10 brought to light. Does that mean if you get care at a DSH
11 hospital, you're a public charge --

12 I guess I want to push a little beyond -- I agree
13 that it's an opportunity to educate. I'm not sure how much
14 that is going to matter, but I am struck by the
15 intersection with eligibility, not just eligibility
16 standards, but eligibility processes. And I'm trying to
17 step back a little bit from where we are today and think
18 about the history of the program.

19 We've made major efforts in outsourcing
20 eligibility, and that means having clarity of message by
21 people who have to understand the rules which, as you note,
22 are not state-consistent. And I think it puts the whole

1 eligibility enterprise at risk if the implications of
2 someone becoming eligible are unknown to the person who's,
3 in theory, helping you become eligible.

4 That feels to me different from sort of the
5 technical question of differences. That how can I look out
6 -- as you say, you come asking for help, and in order for
7 me to know whether or not it's helpful, I have to now know
8 something that I don't know. That's spread through lots of
9 places. This is not just a form you fill out.

10 I also think about how much over the years --
11 and, again, we don't say it so much these days -- there's
12 been attention to outreach, and not just in a state where
13 you're legally required to have coverage, but that great
14 effort has gone into consistent messages of the value of
15 coverage.

16 I'm trying to stay in our lane here -- right? --
17 which is hard.

18 CHAIR THOMPSON: We're all trying to thread this
19 needle. Yeah.

20 COMMISSIONER WEIL: But the lane is what we've
21 been trying to do to try to run the program efficiently and
22 have it meet the need it's supposed to meet does require

1 some ability to be unambiguous about the value of the
2 program from the enrollee's perspective.

3 The moment you pull that away -- again, I'm
4 trying to stay in the lane of not whether it's good policy
5 or not, but it prevents Medicaid from doing something it's
6 spent a whole lot of years trying to figure out how to do.
7 And that feels to me like that's in our lane.

8 CHAIR THOMPSON: I agree. I'm completely
9 comfortable with that. I think that is absolutely a true
10 statement, which is that -- and this Commission has weighed
11 in, for example, on the value of getting to as complete
12 children's coverage as possible and took that into
13 consideration when we made recommendations around CHIP, and
14 a lot of that has to do with the idea that the coverage
15 really matters and making it easy for families to come in
16 and enroll matters and making sure they understand why they
17 should be insured matters.

18 I think that you're right. Not only does it in
19 some ways rub up against that, it also puts kind of a big
20 question mark in that equation for both the beneficiary and
21 for anybody assisting them, including a provider, who might
22 be seeing them for the first time and trying to get them,

1 help them be enrolled in Medicaid, and is that really a
2 good thing for them or not a good thing for them?

3 So I think it's worth pointing out that that
4 tension exists. Again, I don't know that we can weigh it,
5 but we can certainly talk about that aspect of this in the
6 context of this rule. I'm totally comfortable with that.

7 Chuck and then Stacey.

8 COMMISSIONER MILLIGAN: A couple of questions,
9 and I'll do some comments.

10 Martha, forgive me if I missed this, but I'm
11 looking at the language that says "is likely at any time to
12 become a public charge," and what do we know about how that
13 will be predicted?

14 MS. HEBERLEIN: Under the current rule and the
15 proposed rule, it is a prospective looking forward.

16 COMMISSIONER MILLIGAN: Right.

17 MS. HEBERLEIN: But the way they describe how
18 they weigh these sort of -- the financial, the education,
19 all the different criteria that they're going to be looking
20 at is they say, "Well, your past experience can be
21 predictive of your future experience." So we will look at
22 your past receipt of Medicaid as predictive of whether or

1 not you will receive it in the future.

2 COMMISSIONER MILLIGAN: So it's not going to take
3 into account whether you've never received Medicaid, and
4 you might be predicted to receive Medicaid? It's only
5 based retrospectively on whether you have, in fact?

6 MS. HEBERLEIN: So there's other criteria that
7 may come into play. There's things like health status that
8 they're going to be looking at. There's age.

9 COMMISSIONER MILLIGAN: Okay.

10 MS. HEBERLEIN: So it's possible that some of the
11 predictive use of Medicaid in the future might come in
12 under those factors.

13 COMMISSIONER MILLIGAN: Poverty level health
14 status, whatever.

15 MS. HEBERLEIN: Yeah.

16 COMMISSIONER MILLIGAN: My second question is --
17 and, Penny, I want to go back to kind of your comment when
18 you kicked us off about how the eligibility is determined
19 and exchanges and all that stuff.

20 There still are a lot of community organizations,
21 including FQHCs, that do a lot of work with and are
22 authorized to help do Medicaid determinations. Does the

1 proposed rule put any onus on them to do anything with any
2 information they may have received from a potential
3 applicant, like reporting duties or anything?

4 MS. HEBERLEIN: It doesn't talk about, the
5 reporting, where they're going to get the data on public
6 benefit use.

7 COMMISSIONER MILLIGAN: Okay.

8 MS. HEBERLEIN: It also doesn't talk, to the
9 earlier point about, the onus of the providers or the
10 enrollment as sisters would be to educate the applicants
11 about the potential effects of application based on -- for
12 their immigration status.

13 COMMISSIONER MILLIGAN: I want to make, I think,
14 two comments.

15 One is I was the Medicaid director in New Mexico
16 when both welfare reform was passed and CHIP was created,
17 and New Mexico was a border state. The chilling effect was
18 real. There was a lot of concern about applying for CHIP
19 for kids when CHIP was created in the late '90s and whether
20 the parents who might not themselves be citizens would end
21 up finding themselves deported because of all of that kind
22 of stuff.

1 So, at the time, we worked closely with HHS, and
2 at the time, it was Immigration and Naturalization Services
3 to get official letters that this is not going to create a
4 deportation risk, and we had to disseminate it a lot
5 through our promotoras and FQHCs and others who were
6 working with families at the border because there was a lot
7 of concern, in spite of insurance mandates, people will not
8 pursue it if they're going to worry about deportation. It
9 is anecdotal, but it is real, both.

10 The other comment, I guess, I want to make is not
11 to go down the whole DSH rabbit hole again, but there's
12 going to be a disparate impact across states by this kind
13 of thing because of border states being different than non-
14 border states in terms of just prevalence of how this could
15 play out and the uncompensated care implications of some of
16 that. So not to kind of reopen the whole DSH discussion, I
17 do think that to the extent that this rule, if finalized in
18 the form shaping up, it could lead to a state variation of
19 uncompensated care itself created out of this rule that has
20 disparate impacts on states. So I'll just leave it at
21 that.

22 MS. HEBERLEIN: Yeah, good point.

1 CHAIR THOMPSON: Stacey, were you --

2 VICE CHAIR LAMPKIN: I just want to weigh in,
3 acknowledging the trickiness of finding the right place
4 here. I want to weigh in, in support of not only
5 commenting, but having our comments go beyond basic
6 educational -- I think there is a value judgment that we
7 can make based on the value of the coverage itself, based
8 on the concept of a responsibility related to an early
9 warning sign of an access problem.

10 I think we can say here based on historical
11 analog, there does appear to be likelihood of an access
12 problem beyond what the drafters of the regulation have
13 estimated, and we think the coverage has value. So we have
14 a concern about that.

15 CHAIR THOMPSON: Right. But what we can't do is
16 weigh that against the other values that might be outside
17 of our purview.

18 We can express a view about this is moving in the
19 direction opposite from the one that -- or may introduce
20 impacts opposite from ones that the Commission has been
21 trying to work on. So it works at cross-purposes to things
22 that we have been trying to promote.

1 That doesn't mean that that is what rules the day
2 versus other considerations that we cannot, by virtue of
3 our mandate, take into --

4 VICE CHAIR LAMPKIN: Agree, and we can
5 acknowledge that in our letter, with still expressing
6 those.

7 CHAIR THOMPSON: Right, right.

8 Let me just pause here for a moment and see if we
9 have some comments from the public that we should take
10 before summing up and proposing a final direction for our
11 **comments.**

12 **### PUBLIC COMMENT**

13 * MS. HARO: Good afternoon. Is this on?

14 CHAIR THOMPSON: Yes, indeed.

15 MS. HARO: Hi. I'm Tamar Magarik Haro. I work
16 for the American Academy of Pediatrics. The American
17 Academy of Pediatrics is a nonprofit professional
18 association and comprises 67,000 pediatricians.

19 As this entity well knows, we've reached historic
20 levels of uninsurance among children. This proposed rule
21 threatens the health and well-being of millions of
22 children. By some estimates, in addition to the ones that

1 were presented today, we've seen an estimate as high as 9
2 million children could be affected by the proposal.

3 In our view, the proposed rule presents immigrant
4 families with an impossible choice. You either keep your
5 family healthy, but risk being separated or forego vital
6 services like preventive care and food assistance, so your
7 family can remain together in the U.S.

8 The magnitude here cannot be understated. One in
9 four children in the U.S. lives in an immigrant family,
10 meaning that either the child or at least one parent is
11 foreign-born.

12 As this distinguished group knows very well,
13 children enrolled in Medicaid are twice as likely to have
14 routine checkups and vaccinations as uninsured children.
15 Loss of that coverage would have high short-term costs.

16 Children with Medicaid are more likely to receive
17 proper treatment for chronic conditions and less likely to
18 have avoidable hospitalizations. Parents and children's
19 health are inextricably linked, and children do better when
20 their parents are mentally and physically healthy. Parents
21 who are enrolled in health insurance are much more likely
22 to have children who are insured as well.

1 Research demonstrates that safety net programs
2 like SNAP and Medicaid have short- and long-term health
3 benefits and are crucial levers to reducing
4 intergenerational transmission of poverty.

5 The Academy is not alone in expressing its
6 opposition to this proposed rule. We are joined by
7 virtually every major medical provider association in the
8 U.S.

9 I'll just quote at the publication of the
10 proposed rule, the American Academy of Pediatrics joined by
11 the American Academy of Family Physicians, the American
12 College of Obstetricians and Gynecologists, the American
13 College of Physicians, and the American Psychiatric
14 Association all issued a statement in opposition to the
15 proposed rule.

16 In our statement, we said, "Many of the patients
17 served by our members almost certainly will avoid needed
18 care from their trusted providers, jeopardizing their own
19 health and that of their communities.

20 As a result, the proposed regulation not only
21 threatens our patients' health, but as this deferred care
22 leads to more complex medical and public health challenges

1 will also significantly increase cost to the health care
2 system and to U.S. taxpayers."

3 For all these reasons, as well as many of the
4 ones that were expressed by the members of the Commission,
5 we very much hope that you will submit comments. In our
6 view, we believe that this proposed rule should be
7 rescinded.

8 CHAIR THOMPSON: Thank you.

9 MR. ZAMAN: Good afternoon. I'm Shahid Zaman,
10 and I'm here on behalf of America's Essential Hospitals.
11 We represent hospitals and health systems dedicated to
12 high-quality care for all, including the most vulnerable.
13 Our more than 325-member hospitals manage to provide high-
14 quality care while operating on narrow financial margins,
15 half of those of other hospitals across the nation.

16 The average essential hospital provides over \$70
17 million in uncompensated care every year, which is nearly
18 nine times the amount of the national average.

19 We appreciate the Commission's discussion of the
20 Department of Homeland Security's public charge proposal,
21 and we have serious concerns about the proposal and the
22 implications for Medicaid beneficiaries and hospitals

1 serving large Medicaid populations.

2 The proposal would jeopardize the health of
3 millions of lawfully present individuals and threatens the
4 stability of hospitals and the communities they serve. By
5 creating a strong disincentive to seek care, the rule would
6 force people to forego medical visits and medications until
7 they are sicker and costlier to treat.

8 The rule would also deter those who are eligible
9 for and legally entitled to Medicaid from enrolling in
10 Medicaid or would encourage those who are already enrolled
11 in Medicaid to disenroll from the program. It would drive
12 higher levels of uncompensated care, particularly for those
13 hospitals that can least sustain these increased costs.

14 The proposal would reduce access to vital health
15 care services and lead to worse health outcomes.

16 In addition to the financial and health care
17 repercussions of the rule, as the Commission touched upon,
18 it would also impose excessive compliance burdens on
19 hospitals and state Medicaid agencies that are involved in
20 eligibility determinations.

21 We at America's Essential Hospitals are analyzing
22 the impact of the rule and will be providing written

1 comments to the Department of Homeland Security.

2 We also urge MACPAC to continue to analyze the
3 proposal and the devastating consequences it will have for
4 vulnerable populations and the Medicaid program.

5 We do hope that the Commission decides to comment
6 and that will provide comments to DHS on the impact to
7 hospitals and other safety net providers.

8 Thank you, and we look forward to the
9 Commission's work on this issue.

10 MR. D'AVANZO: Hi. Good afternoon. My name is
11 Ben D'Avanzo. I am senior policy analyst at the Asian-
12 Pacific Islander American Health Forum. We are a national
13 advocacy organization that works with Asian-Pacific
14 Islander populations around the country advocating for
15 their good health.

16 We work with a lot of direct service
17 organizations that have already seen the impact of just the
18 rumors about this rule, hearing stories about families
19 asking to disenroll from Medicaid, refusing to use
20 electronic medical services, missing doctors' appointments
21 and the like.

22 We're very concerned about the disproportionate

1 impact that this rule would have on communities of color
2 and especially on Asian-American-Pacific Islander
3 populations. For example, 30 percent of green cards go to
4 people coming from Asian-Pacific Islander countries, and
5 there was a reference to the test that people would be
6 subject to, to determine if they would be likely to be a
7 public charge. That includes an income test that would be
8 negatively weighted if you make under 125 percent of
9 poverty in addition to having potential health conditions
10 that could impact your ability to work or having to prove
11 that you could pay for unsubsidized health insurance, among
12 other factors, including limited English proficiency. We
13 find those very, very worrying and disturbing.

14 We really want to highlight that there is a wide
15 variety of organizations that have spoken out against this
16 rule in addition to providers and hospitals. We have seen
17 plans, immigration groups, Members of Congress, all express
18 concern, a lot because of that lesson of the 1990s, which
19 many of our organizations experienced.

20 You saw in the 1990s, after welfare reform,
21 certain efforts by the predecessor to DHS to target women
22 coming in with small children to the U.S., who had left and

1 are coming back, who are immigrants, asking who had paid
2 for their birth of those children, and if Medicaid had paid
3 for their birth, Medi-Cal in most cases -- this was
4 happening a lot in California -- then those women would be
5 potentially denied entry for being a public charge.

6 This led to a lot of women disenrolling from
7 Medicaid or people disenrolling from Medicaid, and even
8 after the rule was clarified in 1999, because of efforts of
9 a lot of those organizations, there was still mass
10 confusion and concern.

11 The proposed rule places the burden on
12 immigrants. So if you look at the draft form, there is a
13 requirement to list benefits that they have applied for or
14 received in the past. The instructions for the rule just
15 say Medicaid. So in states where Medicaid has a different
16 name, then there is going to be a lot of confusion, or
17 someone just may not know if they are on Medicaid or not.

18 We are definitely concerned about any provision
19 or any implementation that would involve using Medicaid
20 agencies or other entities of having to report data, and
21 the mere existence of this rule has led to people being
22 very concerned about that possibility in both the agencies

1 themselves as well as the organizations and the clients
2 that many of our partners work with.

3 So we definitely encourage you all as
4 Commissioners to weigh in. This is clearly not a rule
5 drafted by people who understand what the health impacts
6 are going to be and it drastically underestimates the
7 chilling effect, and we think that there is a strong role
8 for you all to play in both educating, but also in making
9 it clear that this is not a rule that can be fixed. This
10 is a rule that is unworkable in any form.

11 Thank you.

12 CHAIR THOMPSON: Thank you.

13 MS. WHITENER: Hello again. Kelly Whitener from
14 Georgetown Center for Children and Families.

15 I think in addition to the comments that others
16 have raised, I hope that you will comment. I hope that you
17 will raise the big-picture issues about what this type of
18 rule would mean for children and their families in terms of
19 access to coverage, but I also think you have a pretty
20 unique voice in how you can weigh in on the operational
21 challenges of this rule and not just the challenge to try
22 to make it work, if that's what you were wanting to do, but

1 the costs that would come with that and how it would run
2 counter to the statutory mandates directing Medicaid and
3 directing the Affordable Care Act coverage.

4 So if you think about things like single
5 streamlined application that some of you raised in your own
6 comments, how does that work in the context of this
7 proposed rule, and how should HHS and DHS sort of duke that
8 out? And I think you guys have an ability to shed a lot of
9 light on some of those issues that other groups are not as
10 well positioned to do.

11 So I hope you include that in your comments as
12 well.

13 CHAIR THOMPSON: Okay.

14 Any other comments from the public?

15 [No response.]

16 CHAIR THOMPSON: Any additional reactions or
17 discussion from the Commissioner?

18 [No response.]

19 CHAIR THOMPSON: I did want to pick up on a
20 couple of the points made by the public commenters. I do
21 think that to the extent there is something that people are
22 required to disclose on their applications that say

1 Medicaid, I think that's very consistent with, you know,
2 discussions that we've had about the way in which Medicaid
3 is understood in states, or branded in states, and the
4 extent to which people may not realize because they're in
5 private plans or they're in different systems of care that
6 they are on Medicaid, and if that produces legal risk for
7 the person if they don't properly report that then I think
8 we need to signal to people that it may not be a reasonable
9 expectation for people to have that information.

10 I do think this issue about the need for HHS and
11 DHS to have pretty intense conversations around some of
12 these policies' intention and operational implications is
13 also a point that we can make and suggest.

14 So I think that we want to go ahead and make the
15 comments that we've discussed in the areas that you've laid
16 out here, Martha, for us, in addition to the other
17 additional texture and points that we've made in this
18 Commissioner conversation. It's due December 10th so we
19 won't have an opportunity to discuss this again before our
20 next public meeting, so we'll leave it to the staff to
21 construct that language and we'll have a review by Stacey
22 and I of that information before it's submitted for public

1 comment.

2 Good. Any other comments or questions?

3 MS. VISHNEVSKY: My name is Debbie. I'm a member
4 of the team at the Children's Dental Health Project. I
5 also wanted to highlight that -- so while our focus is oral
6 health, we like to look at oral health under the umbrella
7 of how we make it possible for families to improve their
8 access to success in general and how that impacts the
9 overall health as well as the oral health of their
10 children.

11 I think something else that's also worth
12 mentioning, and I think could fall in the lines of this
13 kind of more specific road that understandably MACPAC needs
14 to focus on, when you make it more difficult for parents to
15 engage in these programs we make it harder for them to get
16 out of these kinds of more challenging circumstances.
17 Without access to oral health, without access to even basic
18 health care programs and preventative care, it's harder for
19 them to keep jobs. It's harder for them to improve the
20 overall kind of circumstances that their family is
21 functioning, and which also impacts the health of their
22 children. And I think that's of vital importance when

1 we're looking at not just how these programs function but
2 also the individuals who are benefitting from these
3 programs. So I think that's also worth considering in your
4 comments.

5 CHAIR THOMPSON: Thank you. I think there is
6 something that maybe just sets the stage here about, you
7 know, we talk about state options for coverage and why
8 states have exercised the options that they have and why
9 they consider coverage for these populations important and
10 why states cover parents and caretakers as well as children
11 and how those related to one another. I think there are
12 some points there that we should make in the introduction,
13 just to kind of set the stage for some of the things that
14 we may want to go on and talk about.

15 Martha.

16 COMMISSIONER CARTER: Commissioner.

17 CHAIR THOMPSON: Commissioner Martha.

18 COMMISSIONER CARTER: I think as you draft a
19 letter I wanted to urge that you word it as strongly as you
20 can, comfortably. I think the potential for damage is
21 great here, and walking the line of what's possible, I
22 would urge you to be as strong as possible.

1 CHAIR THOMPSON: Okay. Thank you.

2 Okay. Thank you very much, Martha. Thank you to
3 the public. Great comments. Appreciate you sharing those
4 with us.

5 **### MANDATED REPORT: MEDICAID IN PUERTO RICO**

6 * CHAIR THOMPSON: Okay. Next up we're going to
7 talk about Medicaid in Puerto Rico and we're going to hear
8 from Kacey on this subject. Welcome back, Kacey, and
9 Stacey is going to take the gavel up at the Chair's table.

10 MS. BUDERI: Okay. So earlier today you heard me
11 talk about Arkansas and this afternoon I will be talking
12 about the Medicaid program in a different part of the
13 United States, Puerto Rico. And this is a topic that the
14 Commission has not discussed before. However, previous
15 work on this has been descriptive. It includes a fact
16 sheet outlining the key features of Puerto Rico's Medicaid
17 program, which was last updated in February of this year,
18 and a slide deck with information on Medicaid financing and
19 spending, published in September of 2017.

20 This presentation today is in response to a
21 congressional request. I'm going to start by reviewing the
22 language from that request. Then I'll provide some

1 background Puerto Rico and some of the economic and fiscal
2 issues it is experiencing. I'll go on to discuss the key
3 features of the Medicaid program in Puerto Rico; which
4 differs in many ways from state Medicaid programs. I'll
5 describe the Medicaid financing and spending situation in
6 Puerto Rico, which, as you may know, is a major and ongoing
7 challenge for the program and the territory because of the
8 capped allotment financing structure it has. And I'll talk
9 about what we know about access to care and quality of care
10 for Puerto Ricans and describe some of the challenges
11 there. I'll conclude with some possible next steps and
12 then turn it over to you for discussion.

13 In the report accompanying the fiscal year 2019
14 Labor, Health and Human Services and Education Funding
15 Bill, the House Committee on Appropriations requested that
16 MACPAC examine possible options for ensuring long-term
17 sustainable access to care for Medicaid beneficiaries in
18 Puerto Rico. This request has no specific due date.

19 Before I get into some of the issues, I want to
20 note that available data on the issues facing Puerto Rico
21 are limited. Most of the data we do have are from before
22 Hurricane Maria hit last September, so we're limited in the

1 information we can provide you today. This presentation
2 draws on the data and information that is publicly
3 available as well as conversations we've had with current
4 and former CMS officials and others knowledgeable about the
5 situation in Puerto Rico.

6 As a little bit of background, Puerto Rico is the
7 oldest and most populous U.S. territory. It has a
8 population of about 3.3 million. Individuals residing in
9 Puerto Rico are U.S. citizens so they can travel to or move
10 to a U.S. state without restriction. While they're
11 residing Puerto Rico they are eligible for many federal
12 programs, including Medicare, Medicaid and CHIP, but they
13 are excluded from others, such as Supplemental Security
14 Income. They generally do not pay federal income tax
15 although they do pay most other taxes, including Medicare
16 tax. They have no voting representation in Congress and
17 they cannot vote in presidential elections.

18 As most of us know, Puerto Rico's economy and
19 infrastructure were damaged significantly by Hurricane
20 Maria, and that damage and recovery have been really in
21 focus. But Puerto Rico has long experienced economic
22 challenges, particularly going back the last two decades.

1 Over this time, Puerto Rico has experienced a major
2 economic decline, with an 8 percent decrease in real GDP
3 from 2005 to 2015. Over the same time period there was a 9
4 percent decrease in labor force participation and a 7
5 percent decrease in population, and this population loss
6 was driven by outmigration of educated and working adults.

7 Puerto Rico also has a substantial debt burden,
8 amounting to \$74 billion in bond debt and nearly \$50
9 billion in unfunded pension obligations. To try to address
10 this, Congress passed the Puerto Rico Oversight Management
11 and Economic Stability Act in June 2016. It's also called
12 PROMESA, which, among other things, created a fiscal
13 control board with discretion over the territory's budget
14 and the power to force debt restructuring.

15 Key economic indicators are significantly worse
16 for families in Puerto Rico than in the United States
17 overall. The unemployment rate is more than twice as high
18 and median income is half the median income in the U.S.
19 overall. Health indicators are more mixed. For example,
20 life expectancy is similar but self-reported health is
21 significantly worse.

22 The uninsured rate is actually lower in Puerto

1 Rico than it is in the United States. The portion covered
2 by Medicaid is a lot higher. In 2017, for example, it was
3 about 47 percent versus 21 percent. Puerto Rico also has a
4 larger share of people covered by Medicare and a much
5 smaller share covered by private health insurance.

6 Given the high Medicaid coverage rate, Medicaid
7 is a central part of the safety net and health care system
8 in Puerto Rico. In 2017, it covered over 1.5 million
9 people, including about 250,000 dually eligible
10 individuals, and about 90,000 Medicaid expansion CHIP
11 enrollees. For the purposes of Medicaid, Puerto Rico is
12 considered a state unless otherwise indicated, so many of
13 the Medicaid rules apply to Puerto Rico. However, the
14 program differs in substantial ways from Medicaid programs
15 in the states, and these differences are primarily related
16 to eligibility, covered benefits, and the financing
17 structure.

18 So in terms of eligibility, Puerto Rico is exempt
19 from requirements to extend poverty-related eligibility to
20 children, pregnant women, and qualified Medicare
21 beneficiaries, and it uses the local poverty level to set
22 eligibility. So it currently covers individuals with up to

1 133 percent of the Puerto Rico poverty level, which is
2 approximately equivalent to just 40 percent of the federal
3 poverty level. And then because individuals residing in
4 Puerto Rico are not eligible for SSI, coverage for aged,
5 blind, and disabled individuals is provided through the
6 medically needy option.

7 Puerto Rico also differs from state Medicaid
8 programs with regard to benefits offered. Puerto Rico is
9 technically required to cover all of Medicaid's 17
10 mandatory benefits but it is currently only providing 10 of
11 them. The specific list is in your materials but notably
12 nursing facility services and non-emergency medical
13 transportation are not covered, and Puerto Rico has cited
14 funding and infrastructure barriers to providing these
15 services. Several optional benefits are provided,
16 including dental care and prescription drugs, and then
17 cost-sharing assistance is provided for dually eligible
18 individuals.

19 Like many states, Puerto Rico uses a managed care
20 delivery system. Beneficiaries are assigned to a plan
21 based on their geographic region. Several concerns have
22 been raised with the current structure, including Puerto

1 Rico's capacity to conduct adequate oversight of the plans;
2 access concerns, particularly with regard to long wait
3 times for needed specialist care, which I'll talk a bit
4 more about later; and then concerns about the adequacy of
5 capitation rates, which have historically been quite low.

6 Puerto Rico is actually in the process of
7 transitioning to a new managed care system that they hope
8 will address some of these problems, and under the new plan
9 the MCOs will provide island-wide coverage rather than
10 coverage to their assigned geographic region, and they'll
11 need to compete for enrollees who will now be able to
12 choose their plan. And this is scheduled to take effect
13 November 1, so next week, but it hasn't been signed off on
14 by CMS yet.

15 Getting to the financing piece, which is central
16 to many of the issues in Puerto Rico's Medicaid program and
17 larger health system, the financing structure for Puerto
18 Rico's Medicaid program differs in two really key ways from
19 the states. First, while Puerto Rico has an FMAP, like the
20 states, it's set in statute at 55 percent. If it were
21 determined using the same formula used for states, which is
22 based on per capita income, we would expect to see it at

1 the maximum allowable rate of 83 percent.

2 And so Puerto Rico draws down federal dollars at
3 this matching rate, but unlike the states it can only do so
4 up to an annual cap, and this cap, which is sometimes
5 referred to as the 1108 cap, was set in 1968 and grows with
6 the medical component of the CPI-U. It does not have a
7 relationship to the cost of the program. For example, in
8 FY 2018, it was \$357.8 million, though actual total
9 expenditures were projected at \$2.62 billion.

10 There are some exceptions to this cap. For
11 example, spending to set up a Medicaid fraud control unit,
12 spending to provide prescription drug cost-sharing to
13 dually eligible individuals does not apply to the cap.
14 However, in general, Puerto Rico cannot access federal
15 dollars beyond this cap.

16 These two financing pieces, the statutory FMAP
17 and the cap, have led to a substantially lower level of
18 federal financing than would otherwise be the case, and at
19 times the federal contribution has dropped to below 20
20 percent of total costs. And so to make up for this, Puerto
21 Rico has historically had to take on a much greater share
22 of program costs than would be expected of a state, or even

1 their 55 percent FMAP would indicate. And one way they
2 have financed this is by issuing bonds which have
3 contributed substantially to Puerto Rico's debt crisis.

4 In recent years, Congress has provided additional
5 federal funds on a temporary basis to help make up for this
6 funding shortfall. The ACA provided a \$6.3 billion
7 allotment in federal Medicaid funds, available to be drawn
8 down any time between July of 2011 and September of 2019,
9 and that's on top of the annual capped amount.

10 Puerto Rico exhausted these funds faster than
11 anticipated and were close to running out by the time
12 Hurricane Maria struck last fall. So in response to that
13 funding running out, and Hurricane Maria, Congress provided
14 \$4.8 billion through the Bipartisan Budget Act of 2018, and
15 that's available for FYs 2018 and 2019. \$3.6 billion of
16 this was guaranteed and \$1.2 billion was conditional on
17 Puerto Rico meeting milestones related to T-MSIS reporting
18 and the establishment of a MFCU, which they have met, so
19 they'll be getting that \$1.2 billion. And Congress also
20 provided a 100 percent federal matching rate for these
21 funds, so Puerto Rico does not need to put up a non-federal
22 share.

1 This graph shows spending and sources of funds
2 for FYs 2011 through 2017, and it illustrates the degree to
3 which Puerto Rico has depended on these supplemental funds
4 that Congress has provided. And you can see that the dark
5 blue area at the bottom is the amount Puerto Rico receives
6 from their annual capped allotment, so that's the 1108 cap,
7 and then the medium blue shade almost entirely reflects use
8 of these temporary additional funds, which for this time
9 period were provided by the ACA, but for 2018 and 2019
10 would be from the BBA.

11 And so because of that BBA funding for FYs 2018
12 and 2019, Puerto Rico will actually have more federal
13 funding available than it is projecting to spend, but any
14 additional funds left over will expire on September 30,
15 2019. After this point there will be no source of federal
16 funds beyond the annual allotment, which we expect to be
17 approximately \$375 million.

18 This situation, when additional federal funds
19 expire or are exhausted, is often referred to as Puerto
20 Rico's Medicaid fiscal cliff. If Congress does provide
21 additional funding but does not extend the 100 percent
22 matching rate there's also the question of whether Puerto

1 Rico would be able to contribute its share of the program
2 cost, given its current fiscal challenges.

3 There is some research around what might happen
4 if Congress fails to provide Puerto Rico with extra funds.
5 When the ACA funds were about to be depleted before the BBA
6 was passed, the Assistant Secretary for Planning and
7 Evaluation at HHS estimated that 900,000 people could lose
8 coverage, and it's not clear what safety net services would
9 be available to individuals who become uninsured in such a
10 scenario.

11 Some studies have also looked at the effect of
12 people migrating from Puerto Rico to a mainland state and
13 found that federal Medicaid costs increase. For example, a
14 2017 report found that at the current migration rates
15 federal Medicaid spending would increase by \$9.7 billion
16 over the next 10 years and state spending would increase by
17 \$6.1 billion. However, these estimates do not account for
18 a potentially faster rate of migration following the
19 hurricane, and some reports indicate the rate has more than
20 doubled.

21 So obviously these financing challenges have been
22 and will continue to be an issue for Medicaid in Puerto

1 Rico. But Puerto Rico is also facing challenges related to
2 access to care. Puerto Ricans receive care in many of the
3 same ways that people on the Mainland do, so in physician's
4 offices, hospitals, health center. Notably there is no
5 long-term care sector in Puerto Rico, which is why the
6 benefits aren't provided under Medicaid.

7 The most recently available data on access in
8 Puerto Rico, which is generally from 2014, indicates that
9 Puerto Ricans at that time had better access to many types
10 of health care than Americans overall, after controlling
11 for economic and demographic factors. However, health care
12 facility capacity and provider availability varied widely
13 across the island. For example, there were more primary
14 care physicians per 100,000 people than in the U.S.
15 overall, but 32 of Puerto Rico's 78 municipalities were
16 designed as primary care shortage areas.

17 Also, access to certain types of specialty care
18 was extremely limited. For example, there were few
19 intensive care unit beds and just one trauma center in
20 2015. There were also few physicians practicing in certain
21 specialties. Examples include emergency room physicians,
22 obstetricians, gynecologists, pediatricians, oncologists,

1 and more, and long wait times for many types of specialist
2 care have been reported as a persistent issue.

3 Of particular concern following the hurricane has
4 been the need for behavioral health services, and we don't
5 have any data on unmet needs for these services but there
6 have been many anecdotal and media reports about this
7 issue. And then underlining these access challenges has
8 been a declining provider workforce due to outmigration,
9 and this is a trend prior to the hurricane, and by all
10 anecdotal accounts has gotten a lot worse following the
11 hurricane. One reason is that salaries are low compared to
12 the relatively high cost of living in Puerto Rico, and they
13 are also low compared to salaries on the mainland. So to
14 help address this issue, Puerto Rico increased Medicaid
15 payment rates to 100 percent of the 2018 Medicare rates
16 earlier this year, but the effects are unclear so far.

17 So in terms of quality of care, the data that is
18 available show a mixed picture when compared to the U.S.
19 overall. For example, in 2014, Puerto Ricans were more
20 likely to have a usual source of care than people in the
21 U.S. overall. However, they were less likely to receive
22 certain types of screenings, for example, for colorectal

1 cancer or Pap tests, and they also had lower vaccination
2 rates among children.

3 And while some of the access issues may
4 contribute to this, some reports have also cited
5 infrastructure-related challenges, particularly a lack of
6 key equipment in hospitals and slow adoption of health
7 information technology as barriers to improving quality of
8 care.

9 So again, because of the gaps in available data,
10 we are limited in the information we can provide you with,
11 and it may be hard for the Commission to make specific
12 recommendations at this stage. However, we anticipate that
13 we could include a descriptive chapter in the March 2019
14 report to Congress that could serve as our response to the
15 Committee request, and if there are specific areas that
16 you'd like us to look further into we can do that, and we
17 can also convene a panel at an upcoming meeting if you'd
18 like to hear more from people knowledgeable about the
19 situation in Puerto Rico.

20 So I'll stop there.

21 VICE CHAIR LAMPKIN: Thank you, Kacey, very much,
22 and you've done a really good job in describing what can be

1 known at this time and the complexity of the current
2 situation and the complexity of the potential options that
3 could be considered to improve. It's really sobering
4 information. And you've also, I think, very usefully laid
5 out some important context in history about how the
6 Medicaid financing has -- the interplay with that and the
7 economic situation and the way that's developed. That's
8 great context.

9 Before we open it to Commissioner discussion and
10 questions, though, I have a question for you about maybe do
11 we have -- about the congressional request itself and the
12 kind of context there. It sounds like from your planning
13 that the fiscal cliff is expected when current extra
14 funding runs out next September. And so is this request in
15 the context of that and Congress is looking for guidance
16 and input kind of leading into that -- how to address that
17 fiscal cliff? Or do we have additional context around
18 that?

19 EXECUTIVE DIRECTOR SCHWARTZ: As Kacey stated,
20 there's no date specified, and it really was only a one-
21 line request. You know, I think we've heard from the
22 authorizers that they're interested in this topic, too.

1 But, you know, it -- we can provide information. They'll
2 be getting information from, obviously, the Commonwealth
3 itself.

4 VICE CHAIR LAMPKIN: Okay, thanks. That was
5 helpful. It's sort of vague language in the original

6 EXECUTIVE DIRECTOR SCHWARTZ: Yes, extremely
7 vague.

8 VICE CHAIR LAMPKIN: Okay. All right. With that
9 great background, Kit, can you kick us off?

10 COMMISSIONER GORTON: Sure. Thanks, Kacey.
11 Lovely job. So I'm going to start with two things.

12 First, a lot of emphasis in the media coverage
13 and even in the request from the authorizers about the
14 uniqueness of the Puerto Rico situation, and I don't want
15 to diminish that in any way. But I do think we have some
16 places that we might be able to learn things, and I fear
17 that with the typhoon bearing down on Guam, we may have
18 other opportunities to learn as well. So worth thinking
19 about things in a broader context perhaps.

20 So the first thing I would like to suggest is
21 that we -- one of the things we might be able to offer
22 folks is a look back at what happened in places like New

1 Orleans after Katrina, where we saw many of the same
2 phenomenon going on -- huge outmigration -- and one of the
3 things, I think, that the folks in New Orleans taught us is
4 that they needed not to plan for the future of New Orleans
5 to be the past of New Orleans. They needed to plan for New
6 Orleans to be the New Orleans it was going to be. So they
7 shrunk the school district by some outstanding proportion
8 because all the students moved out.

9 On the health care side, I had the opportunity to
10 be working in a health plan serving Louisiana after the
11 storm, and one of the things that happened is that people
12 with complex medical conditions often got moved out because
13 they couldn't be cared for in Louisiana during the -- and
14 Fred probably has a point of view about this as well --
15 because they couldn't be cared for. The infrastructure had
16 just disappeared. Many of those people didn't go home, and
17 so one of the things to think about is where -- and as we
18 think about Puerto Rico, where are these people potentially
19 landing? Historically there's a huge relationship between
20 Puerto Rico and New York City, and people go back and
21 forth. There's easy travel back and forth and, you know,
22 so it will be interesting to see whether the folks in New

1 York are experiencing children with complex medical
2 conditions appearing there that hadn't been there before,
3 that kind of thing. And, again, this data may not be
4 knowable. These may just be questions that we can ask at
5 this point. But it seems to me that we can look at some of
6 the experiences from Katrina. There may be other examples
7 that come to other people's minds, and then use that to
8 potentially inform what are we trying to accomplish with
9 the rehabilitation of Puerto Rico and what did people
10 manage well in New Orleans in terms of getting
11 professionals to come back and other things like that, what
12 didn't go so well. So there may be some lessons to be
13 learned from that that we can help assemble from the health
14 care and Medicaid front.

15 Which takes me to the second point that I want to
16 make, the descriptive data that you provided us was
17 fascinating, but, you know, given the short period of time
18 you had to pull it together, most of it was sort of
19 comparisons with national means. And Puerto Rico wasn't
20 anywhere near the national mean for most things going into
21 the storm, and the likelihood that they get anywhere near
22 the national mean after the storm is pretty remote, at

1 least in the near term. And so I wonder whether it's
2 appropriate to use other comparators. Should we be looking
3 at the lowest quintile of states to see how they were
4 performing against them before the storm and how they do
5 after? And I'm not suggesting we pay no attention to
6 national means, but we want to be realistic in terms of
7 what are we going to be able to accomplish, and I think we
8 want to have a realistic sense of how bad it is. Once the
9 data starts coming out, you know, are they functioning
10 within the lowest quintile of states or not? And if
11 they're not, how far below are they that? That to me seems
12 to be a more reasonable comparison than just the U.S. mean.
13 And the other slice of that is the raw data. Puerto Rico
14 is predominantly Hispanic and Spanish-speaking, so if you
15 are going to norm their health outcomes, you need to norm
16 them -- now, it's the majority language in Puerto Rico, but
17 still, the genetic base and the cultural background and
18 other things match Hispanic populations on the mainland.
19 And so I think that it's worth thinking about, okay, how do
20 Puerto Ricans in Puerto Rico measure up to Puerto Ricans in
21 New York? How do they measure up to Puerto Ricans in the
22 southern border states? So I just wanted to think about

1 other ways that we could illuminate the situation there to
2 make sure that we had sort of the full context in order to
3 help people assess what fixes they wanted to put in place.

4 VICE CHAIR LAMPKIN: Thanks, Kit. So maybe we go
5 Brian and then we have Kisha, Sheldon, and Fred.

6 COMMISSIONER BURWELL: So great job, Kacey. My
7 takeaway from reading this chapter is that things are
8 really messed up in Puerto Rico, and, you know, there's
9 various contradictory things. It's obviously a program
10 that Congress intentionally underfunded, you know, 55
11 percent FMAP, it's got a cap on it. You know, there was
12 like a conscious policy decision that we're not going to
13 give Puerto Rico the same federal share that we give other
14 states, and somehow, you know, it's going to be a lower
15 quality health care system than we have elsewhere, and that
16 seems to have been the case.

17 And in response, Puerto Rico seems to have been
18 very kind of -- it's not really complying in terms of
19 running it like a Medicaid program. You know, we only
20 cover 10 out of 17 mandatory benefits, et cetera. But then
21 there's all these infusions of federal money lately that
22 actually has greatly increased the federal investment to

1 the point where in the current fiscal year they have more
2 money than they will spend. It just makes no sense to me.

3 So, I mean, is this a Medicaid program that we
4 really shouldn't call a Medicaid program? It's capped.
5 It's not an entitlement. Is there a need to just break it
6 off from Medicaid and have it as a block-granted federal
7 health care, you know, program and just run it in
8 accordance that's appropriate for the circumstances of
9 Puerto Rico? I don't know. I mean, that's a pretty
10 extreme recommendation for us to make in a report, but it
11 just seems to be a situation that requires fairly radical
12 policy intervention rather than, you know, somehow trying
13 to make this -- continue to run this as somewhat of --
14 somewhat like a Medicaid program.

15 COMMISSIONER DAVIS: I think I would love to hear
16 from a panel of folks in Puerto Rico to get the on-the-
17 ground perspective, especially because there's so much
18 difficulty in getting the data and to hear more about the
19 before and after. What we have is really from 2014, and so
20 to really get that perspective of what things are like on
21 the ground, and I would love to hear that perspective.

22 I think the other thing that strikes me is just

1 the inconsistencies in primary care, and we know that a
2 strong primary care workforce would be helpful, and there's
3 inconsistencies in how it's paid for. So are there
4 opportunities where Medicaid can be helpful in that in
5 terms of thinking about different ways to pay for primary
6 care that would encourage providers to come back? And also
7 thinking about how Medicaid pays for telemedicine, and is
8 that a way to account for some of the brain drain issues
9 that they're facing in terms of specialists and ways that
10 they can collaborate more with folks in the mainland to
11 kind of make up for some of those deficits?

12 VICE CHAIR LAMPKIN: Thanks. Sheldon, then Fred,
13 then Chuck.

14 COMMISSIONER RETCHIN: I thought that was a
15 really terrific report, Kacey, and certainly spurs for me a
16 lot of thoughtful interest in Puerto Rico. I do think
17 Brian's comment, though, is like an above-the-fold comment,
18 a headline, that it's Puerto Rico, I would conclude, is
19 really messed up.

20 So here's where I -- first of all, I wanted to
21 ask a question that was puzzling in the report, that the
22 primary care density is actually higher in Puerto Rico than

1 in the mainland?

2 MS. BUDERI: The report that I saw said that
3 there are more -- at that time -- I think it was 2014 --
4 there were more primary care physicians per 100,000 people
5 than in the U.S. overall.

6 COMMISSIONER RETCHIN: Which I think must be
7 indicative of just a different approach to care, and maybe
8 the emphasis of Medicaid managed care in particular, but,
9 still, that they're able to hold on -- or were before the
10 storm. But let's be clear. The storm simply precipitated
11 the trend that's been there for more than a decade, and
12 physicians are leaving the island at four times the rate of
13 the population. But I wonder -- and so that's of great
14 concern to me in terms of the long-term viability. And I
15 wonder, in a report for the issue of long-term
16 sustainability, is this sort of PAYGO, that with the people
17 moving off the island, if they're -- and we don't know.
18 Are they leaving the island because they're going to leave
19 anyway and it's been accelerated by the storm? Or is the
20 concern over the health care infrastructure, does it have
21 any influence in that? Because we're not going to fix the
22 island. We're not going to fix the debt, which is

1 essentially is a municipal default. But do you have any
2 anecdotal information on that?

3 MS. BUDERI: I've seen reports that indicate
4 that, in addition to the lower relative salaries,
5 physicians have cited contributors like there being a lack
6 of good training opportunities in Puerto Rico and a lack of
7 key equipment in health facilities, for example, MRIs, lack
8 of good hospital infrastructure. But I don't really have
9 anything firm to share with you on that.

10 COMMISSIONER RETCHIN: Okay.

11 VICE CHAIR LAMPKIN: Fred.

12 COMMISSIONER CERISE: Well, I have seen some of
13 this before, the post Katrina experience, and, you know, it
14 does lend itself to big ideas, as Brian said, you know, do
15 you want to just redo the whole thing, because here's your
16 opportunity. And that same discussion went around New
17 Orleans after Katrina. I can remember the Secretary spent
18 a fair amount of time down there and said, you know, talk
19 to Medicare, Medicaid, CDC, HRSA, SAMHSA, get everybody in
20 the room and just make it up and do it differently. You
21 know, we're going to make this the model for redesign, but
22 nobody could -- everybody had rules to follow, and so you

1 made some incremental changes, you did a little bit better
2 in primary care as things grew back. But it looks the same
3 as the rest of the health care world.

4 And so, you know, it is a time to reflect and
5 say, all right, if you are putting the pieces back
6 together, if you can invest heavily in this, do you want to
7 be more intentional about how you do it? And so I do think
8 it's worth thinking about.

9 Some of the differences, you know, when the
10 population goes away and you don't have the people to
11 practice on and health care providers go away at an
12 accelerated rate as well, in New Orleans you had big
13 hospital systems that supported the -- somebody had to
14 float the provider system while you didn't have patients to
15 pay for it, and so some of the big systems supported their
16 specialists so that they wouldn't leave. But they were
17 essentially paying for them, but they weren't doing work.
18 And so there was a buffer that was built in there that you
19 don't have in Puerto Rico, and so I have no doubt they're
20 feeling it more acutely there.

21 You know, everybody has talked about sort of the
22 problems that existed there before that no doubt have been

1 exacerbated. You can't help thinking of if almost half the
2 population is covered through Medicaid, to Brian's comment,
3 you're halfway there already. And if you're going to be
4 able to support some of the physicians staying, some of the
5 other health care providers staying, you know, it probably
6 should involve some intentionality, you know, if you're
7 going to invest and you really can't expect systems to be
8 healthy if they don't know what's coming after next year,
9 when you see the graphs of, you know, a fix this year, a
10 fix this year, a fix the next year, and for these public
11 institutions to be able to build something sustainable,
12 they have to know something's going to be there beyond two
13 years from now. And so it seems like, you know, if you
14 really wanted to dive into this, you would be more
15 intentional about a design and then make a multi-year
16 commitment to stay the course.

17 VICE CHAIR LAMPKIN: Thanks, Fred. Chuck.

18 COMMISSIONER MILLIGAN: I definitely wanted to
19 hear from Fred before I commented. I continue to have
20 tremendous respect, Fred, for what you did to lead things
21 in Louisiana after Katrina.

22 I have a question or two, Kacey, and then a

1 couple of comments. You did a great job laying out the
2 background. Puerto Rico is one of five territories. Do we
3 know contextually whether the other territories have
4 similar challenges with capped allotments and FMAP limits
5 and structural challenges? Do we know about the Virgin
6 Islands and Guam and Mariana and American Samoa? Do we
7 know much about is Puerto Rico representative of that
8 situation for territories pre-Maria or is it anomalous? Do
9 we know?

10 MS. BUDERI: Puerto Rico was definitely the
11 territory of the five that struggled the most with their
12 capped allotment and where that had been set. All of the
13 other territories also have a capped allotment. We
14 actually have fact sheets on each of the other territories'
15 Medicaid programs, and they all work a little bit
16 differently. But in terms of their underlying fiscal
17 situations and their access issues and their broader health
18 systems, I don't really know much about them.

19 EXECUTIVE DIRECTOR SCHWARTZ: There are a couple
20 of differences I think we can point to. First of all,
21 Puerto Rico swamps the other territories in terms of its
22 size. So it's much bigger in terms of people. It's much

1 bigger in terms of geographic area. And I believe,
2 although I haven't read the fact sheets recently. First of
3 all, U.S. Virgin Islands is obviously extremely affected by
4 the hurricane. The Pacific territories don't have as much
5 of a private health system infrastructure. There's usually
6 a couple large hospitals or health centers, which is where
7 everybody gets their care. And I believe in Guam,
8 basically everyone is just assumed to be eligible for
9 Medicaid. So Puerto Rico -- sort of stands somewhere
10 between those territories and what you would see in a state
11 on the mainland.

12 MS. BUDERI: I would certainly say that the
13 Medicaid program in Puerto Rico and the U.S. Virgin Islands
14 are the most similar ones to the state Medicaid programs.
15 The Pacific territories work, as Anne was saying, much
16 differently. For example, in American Samoa -- you said
17 Guam, but it's American Samoa. They get basically -- you
18 know, everyone gets provided health care when they go to
19 the public hospital, and then Medicaid actually is just a
20 financing stream, and they calculate how much money based
21 on -- I mean, it's in the fact sheet. But it's based on
22 the percentage of people under 200 percent of the poverty

1 level, I believe.

2 COMMISSIONER BURWELL: I just want to say I had a
3 nice conversation with the Medicaid director in Guam a
4 couple weeks ago, and she cited herself as the only
5 Medicaid director that was also on Medicaid.

6 [Laughter.]

7 COMMISSIONER MILLIGAN: So when we report to
8 Congress, I think just a little bit of like a text box
9 about some of this would be good context.

10 I guess my main comment is my assumption is that
11 the reason Puerto Rico is called out for purposes of our
12 involvement is the hurricane, and so I think we need to
13 determine kind of like the focus of how we handle this
14 request is Puerto Rico as a territory versus Puerto Rico as
15 devastated by a hurricane. And I think the latter needs to
16 be kind of the through thesis of how we approach this, and
17 -- because I assume that that's why Congress -- I'm making
18 an assumption here, but I think that that's why Congress
19 was looking for some information from us. And so I think
20 wherever we take this -- and, you know, I defer to the
21 group as a whole -- I think it has to be in the context of
22 what's the right federal response in the face of a

1 devastating natural disaster that a community can't itself
2 recover from without some support. So I think -- as
3 opposed to the implications of being a territory. So that
4 would be my suggestion.

5 CHAIR THOMPSON: Okay. I'll just jump in. I
6 think the -- given Anne's answer to what do we know about
7 what people were really looking for from us, I'm not sure
8 that it's hurricane as much as it is the expiration of some
9 funding authorities and trying to get ready for that. So I
10 think we should figure that out -- I mean, I think if we
11 can validate any of that and get a sense about what people
12 are really looking for from a focus perspective, because I
13 think you're quite right, those are --

14 COMMISSIONER MILLIGAN: But, Penny, if -- that's
15 one of the reasons I started by asking about the other
16 territories. I don't know if they're in the same debt
17 situation. I don't know if they're upside down in terms of
18 how to finance Medicaid.

19 CHAIR THOMPSON: Oh, yes. I'm not suggesting
20 that it's about territorial financing as opposed to Puerto
21 Rico versus Puerto Rico with a hurricane.

22 COMMISSIONER MILLIGAN: Okay. I just -- whatever

1 context we can lend then to the situation going into the
2 hurricane as distinct maybe from the other -- I think we
3 need to contextualize -- and that's why I started with my
4 question that way.

5 MS. BUDERI: If it's helpful for you, Chuck, I
6 can tell you that Puerto Rico is the only one that was
7 bumping up against that ACA allotment. I think Northern
8 Mariana Islands was getting close, but Puerto Rico was the
9 only one that was actually -- the other territories are
10 still using their ACA allotments. Puerto Rico is the one
11 that ran out and is constantly bumping up again that extra
12 funding.

13 EXECUTIVE DIRECTOR SCHWARTZ: I think those are
14 great points, Chuck, and I think that we can provide some
15 context for that. I think in some ways the issues are sort
16 of inextricable because you have to think about post-
17 hurricane but also what what was the thing that you were
18 building on. And if that has got its own set of concerns,
19 you have to acknowledge those as well.

20 I'm not sure we will get more guidance, but I
21 think your point is well taken, and I think it's one that's
22 not terribly difficult for us to incorporate in our

1 narrative.

2 VICE CHAIR LAMPKIN: So Melanie and then Bill.

3 COMMISSIONER BELLA: So this is just since I
4 still can claim being new kind of question.

5 Will we talk to Medicaid officials in Puerto Rico
6 and talk to them about where are you struggling, how can we
7 be helpful, like what kind of issues are you facing? Can
8 we actually try to be helpful from their perspective in
9 writing this report?

10 MS. BUDERI: Yes. So I'm in touch with them, and
11 I've talked to them several times. And I can continue to
12 do that.

13 EXECUTIVE DIRECTOR SCHWARTZ: And maybe that's
14 who we can also invite to come for a panel or you to hear.
15 I mean, there are a number of perspectives that we could
16 hear from Puerto Rico, and honestly, based on the number of
17 convenings here in Washington, I think they tend to be
18 happy to come if we can make the scheduling work for them.

19 So we could hear from the health plan. We could
20 hear from the Medicaid director. We could hear from the
21 primary care association. We can figure it out.

22 COMMISSIONER MILLIGAN: And we can hear from our

1 former MACPAC Commissioner who is doing a lot of work there
2 too.

3 EXECUTIVE DIRECTOR SCHWARTZ: Yeah. And we've
4 been talking to him too.

5 COMMISSIONER SCANLON: I am going to go back a
6 little bit to where Chuck was.

7 I think it's important to understand the broad
8 context and not just in the health care system and in
9 territories, but the context of the economies. I had this
10 sense that the economy of Puerto Rico has been different.
11 This is conjecture, maybe, not based on a lot of strong
12 evidence on my part, but that they had probably a stronger
13 manufacturing sector that have some of the other
14 territories that maybe rely more on tourism sort of as a
15 principal economic driver.

16 The question of sort of all of their debt, I
17 mean, how much of that is a function of their tax policies?

18 I want us not to be naïve when we draw
19 conclusions from their situation, but I also want us to
20 investigate all of these things because we obviously can
21 influence all of these things. The fact is their situation
22 today is their situation today. What the historical causes

1 are may be important, and they may not, and we're not going
2 to change them. We need to at least spend some of our time
3 thinking about sort of how they might fit.

4 VICE CHAIR LAMPKIN: Darin, and then we'll wrap.

5 COMMISSIONER GORDON: I'd just say with the
6 exception that some of those underlying structural issues
7 that you're talking about -- sustainability, understanding
8 what those have been -- could lend insight to how we come
9 up with a sustainable path forward.

10

11 VICE CHAIR LAMPKIN: So this has been good. I
12 want to just quickly summarize. It seems to me like we
13 have a couple of different areas here.

14 One is some other kinds of comparatives or
15 relevant information, post-Katrina, Louisiana, that we
16 could bring into a descriptive Puerto Rico chapter for
17 context and comparison, and then another is potentially
18 bringing a panel to talk to us and maybe even get into some
19 solutions or options that telemedicine or other technology
20 -- are they relying on medical tourism, Miami, in some kind
21 of context, something there to help us understand what
22 they're doing in the short term and what they think some of

1 the longer-term options might be.

2 Is that --

3 COMMISSIONER BURWELL: Our mandate is to evaluate
4 long-term sustainable access, but I'm sure if people from
5 Puerto Rico come, they're all going to be about the cliff
6 in 2020. So it's definitely a short-term/long-term
7 problem, and how do we want to approach each of those?

8 CHAIR THOMPSON: And maybe that's a specific
9 charge to the panel to try to elucidate and segment those
10 two questions. That could be, I think, very interesting to
11 talk about the shorter versus the longer term.

12 Thanks, Kacey, so much.

13 VICE CHAIR LAMPKIN: Yeah. Thanks.

14 CHAIR THOMPSON: Okay. Great.

15 We had a public break scheduled -- a public
16 comment and break. Let me go ahead and ask for public
17 comment on this discussion, but we're not going to take a
18 break. We're just going to keep going and finish out the
19 day since we started a little bit late.

20 **### PUBLIC COMMENT**

21 * MS. HALL: Hi. Cornelia Hall from the Kaiser
22 Family Foundation.

1 We've been also tracking a lot of the work, the
2 hurricane recovery in Puerto Rico and the Virgin Islands,
3 and involved with a couple of people here on that, so
4 thanks to Kacey and everyone for this report.

5 I just wanted to underline a few things that you
6 said based on our research and our conversations with
7 territory health officials, providers, Medicaid directors.

8 It all comes back to the FMAP and the cap for
9 them. So, as you all were just saying, I think if you
10 heard from them, there's just a lot of concern and anxiety
11 about the fiscal cliff, and as they are recovering from the
12 hurricane, implementing these managed care changes, and
13 also anticipating that fiscal cliff, there just are a lot
14 of strains on the Medicaid program in those two territories
15 right now. So I just wanted to highlight and underscore
16 the FMAP as the primary concern that we've been hearing
17 over and over again from them.

18 Also, two points that Kacey made that I just
19 wanted to underscore, due to the out-migration that began
20 before the hurricanes, the population that's left in Puerto
21 Rico is disproportionately older and sicker and disabled
22 and has lost a lot of social supports that they had, family

1 members and other people, before the hurricanes. So that
2 might also be something to consider when looking long term
3 at the fixes to the Medicaid program there.

4 Then also as you mentioned, it's a regional
5 issue. In Puerto Rico especially, we've heard areas around
6 San Juan and other metropolitan areas have recovered more
7 quickly than the mountainous regions and the two offshore
8 islands of Vieques and Culebra, which are both still off
9 the grid and are going to be using generators for the next
10 two years. And the population on Vieques is still going to
11 the mainland for dialysis.

12 The same thing in the Virgin Island and St.
13 Croix. I think they still don't have full dialysis
14 services there. So there's still a lot of recovery still
15 going on over a year after the hurricanes.

16 Then just to put in a quick plug in response to a
17 couple of questions, we released our 50-state budget survey
18 today, but we also, for the first time, have a supplement
19 with the territories. We've interviewed all of the five
20 territory Medicaid directors. That's going to be coming
21 out in a couple weeks, and it might be useful for all of
22 you in your work ahead.

1 So thanks so much.

2 CHAIR THOMPSON: Thank you.

3 Did you bring us copies of the 50-state surveys?

4 We're all eager --

5 MS. HALL: Yes. It's just up the street.

6 [Laughter.]

7 CHAIR THOMPSON: Thank you very much for those
8 comments.

9 Okay. We'll move on now to Chris Park, and we're
10 going to talk about Medicaid drug coverage and talk about
11 the results of some work that you've been doing, Chris, on
12 comparison of Part D and commercial plan formularies and
13 Medicaid drug coverage.

14 **### COMPARISON OF MEDICAID DRUG COVERAGE TO MEDICARE**
15 **PART D AND COMMERCIAL PLANS**

16 * MR. PARK: Thank you, Penny.

17 I'll just let people move around a little bit.

18 Okay. At our December meeting last year, we
19 heard from our panel that while Medicaid has had success in
20 managing utilization for many traditional drug classes, the
21 available management tools are less effective in containing
22 costs and utilization for high-cost specialty drugs.

1 Some states have expressed interest in adopting
2 commercial-style formulary tools. In particular,
3 Massachusetts recently submitted a Section 1115 waiver
4 amendment seeking to adopt a closed formulary. This
5 request was ultimately denied by CMS.

6 The Commission has expressed interest in better
7 understanding how Medicaid's management of drugs compares
8 to other payers and whether states need more tools to help
9 them control drug spending.

10 MACPAC has contracted with IMPAQ International to
11 conduct an analysis to compare Medicaid coverage of drugs
12 under a preferred drug list to Medicare Part D and
13 commercial plan formularies. This project assesses whether
14 Medicaid offers broader coverage than other payers and how
15 this coverage and other restrictions vary across payers.

16 This presentation will present findings from the
17 first phase of this project. The second phase, which will
18 link the formulary information that we found in this
19 initial phase to actual utilization, and that is scheduled
20 to be completed next spring.

21 So, as a quick refresher, payers have different
22 requirements regarding drug coverage. For Medicaid, the

1 program must generally cover all drugs as part of the
2 rebate program.

3 For Part D, plans must offer at least two
4 chemically distinct drugs in each category and class. For
5 six protected classes, they must offer all or substantially
6 all of the drugs offered in those classes.

7 For commercial plans that are required to provide
8 essential health benefits, plans must cover the greater of
9 either one drug in every class or the same number of drugs
10 in a class as the benchmark plan.

11 For other commercial payers, such as self-insured
12 employer-sponsored plans, there are very few requirements
13 for those plans.

14 For this analysis, we selected a sample of 261
15 brand and generic drugs that represented a broad selection
16 of both high-cost drugs and highly utilized drugs across 29
17 drug classes.

18 We ultimately determined coverage if either the
19 brand or generic version was covered. So this ultimately
20 meant that our comparison was made on 130 unique chemical
21 products selected in our sample.

22 We obtained formulary and plan information from

1 Managed Market Insight and Technology and used data from
2 December 2017.

3 For each plan and payer, we looked at the number
4 of covered drugs as the way to measure the breadth of
5 coverage and the availability of drugs for each payer. We
6 also looked at the number of unrestricted drugs; that is,
7 drugs that did not have any utilization management
8 restriction, such as prior authorization, step therapy, or
9 quantity limits.

10 A low number of unrestricted drugs in a class
11 would indicate that the plan formulary had a high level of
12 utilization management.

13 For both the number of covered drugs and
14 unrestricted drugs, we also identified formularies that
15 were considered outliers with extremely low coverage for
16 each drug class.

17 For the outlier analysis, we calculated a
18 threshold that represented the minimum number of covered or
19 unrestricted drugs required to be on a formulary to not be
20 considered an outlier. For example, there were 13 drugs in
21 the second-generation atypical anti-psychotics class, and
22 we calculated an outlier threshold of 10. So that means if

1 a formulary offered fewer than 10 drugs in that class, it
2 would be considered extremely low, and that formulary was
3 flagged as an outlier.

4 For each class, we calculated thresholds at the
5 national level as well as state-specific thresholds, and in
6 addition, for each payer, we identified the percent of
7 covered lives that were affected by a formulary that was
8 considered an outlier in at least one drug class.

9 So, generally speaking, Medicaid formularies had
10 broader coverage than Medicaid Part D or commercial plans.
11 The median number of covered drugs for Medicaid formularies
12 was greater than or equal to Medicare and commercial
13 formularies in all of the drug classes reviewed, and
14 Medicaid had a higher median number of covered drugs in
15 eight classes, as seen on this slide, than both commercial
16 and Medicare Part D plans.

17 Based on the outlier test, Medicaid also appeared
18 to offer broader coverage for both the national and state
19 threshold standards. Medicaid had about 18 percent of
20 covered lives affected by a drug coverage outlier at the
21 national level compared to about 50 percent of lives for
22 both Medicare and commercial payers.

1 And if we use the state-level test, it also shows
2 a similar relationship with Medicaid having a fewer percent
3 of covered lives affected.

4 In addition, as shown in the dotted circle, we
5 looked at Medicaid fee-for-service compared to Medicaid
6 managed care, and Medicaid fee-for-service had a lower
7 percentage of lives affected by drug coverage outliers than
8 managed care.

9 Part of this difference between fee-for-service
10 and managed care may be due to how certain drugs are
11 covered by managed care. Certain drugs may be carved out
12 of the managed care plans, and we're not exactly sure how
13 these drugs may be represented in the data. Certain drugs
14 may not appear on a managed care formulary, but the
15 beneficiary may ultimately be getting coverage on the fee-
16 for-service side for those drugs.

17 While Medicaid generally covered more drugs, they
18 may place more restrictions on drugs. In general, most of
19 the formularies across all three payers had a low number of
20 unrestricted drugs in each class, indicating that most
21 formularies put some level of restriction on almost all of
22 the drugs in the class.

1 Medicaid generally had a similar number of
2 unrestricted drugs as the other two payers; however,
3 Medicaid did have a lower median number of unrestricted
4 drugs than commercial and Medicare plans in six classes, as
5 shown on this slide here.

6 Based on the outlier analysis on utilization
7 management restrictions, we kind of see a mixed picture.
8 Based on the national standards, Medicaid had more lives
9 affected by outliers; however, as I mentioned earlier, most
10 formularies across all three payers included restrictions
11 for all or mostly all of the drugs in a class.

12 At the national level, we are only able to
13 calculate an outlier threshold for one class, which was the
14 immune suppressant DMARDs, and so what you see here is
15 really kind of reflecting differences in utilization
16 management for that one particular class.

17 When we looked at the state-level thresholds, we
18 were able to calculate thresholds for nine classes, and
19 here, you can see that Medicaid is somewhat in between
20 Medicare and commercial. It's higher than commercial and
21 lower than Medicare.

22 Again, looking at the difference between fee-for-

1 service and managed care, it appears fee-for-service has
2 fewer, has lower restrictions than managed care and kind of
3 similar to what we saw for the drug coverage.

4 So for the takeaways, broadly speaking, these
5 results show that Medicaid programs generally have the
6 ability to manage prescription drugs in a similar manner as
7 other payers. While Medicaid generally covers more drugs
8 than other payers, it tends to place restrictions on these
9 drugs and use utilization management tools at a similar or
10 higher rate than other payers.

11 However, the differences in coverage for specific
12 classes or specific drugs across payers may be larger. For
13 example, 84 percent of Medicaid lives have formulary
14 coverage for Exondys 51, which is a drug used to treat
15 Duchenne muscular dystrophy, compared to 61 percent of
16 commercial lives.

17 This analysis also has a few limitations. The
18 comparison does not take into account any differences in
19 formulary tiering or cost sharing. So while copayments of
20 Medicaid are nominal, Part D and commercial plans can use
21 differences in cost sharing as another tool to manage use
22 and direct beneficiary behavior toward preferred drugs.

1 Also, this analysis is a point-in-time analysis.
2 So coverage differences across payers may be larger at
3 certain points in time, particularly during the first few
4 months when a new drug comes to market, as Medicaid
5 generally must cover these drugs immediately, while
6 commercial payers and Part D have around like 180 days to
7 make a coverage decision.

8 Additionally, it's important to note that this
9 first phase of this analysis does not look at how these
10 coverage policies actually tie to utilization in these
11 classes. Even though payers may have prior authorization
12 requirements for the same drug, this does not mean that
13 those requirements have the same level of restrictiveness
14 or lead to a similar distribution of drugs within a
15 particular class. We have begun work on second phase of
16 this project to link to formulary policies to utilization
17 to better understand the practical effects of these
18 policies.

19 We believe this additional information will be
20 helpful to you in assessing Medicaid's ability to manage
21 utilization of spending and whether additional tools are
22 needed.

1 We would appreciate any feedback you have on this
2 first phase of analysis. As I mentioned, we're starting
3 the second phase right now, so we do have an opportunity to
4 take into account some of your comments and may be able to
5 address some of those in the second phase.

6 CHAIR THOMPSON: Thank you, Chris.

7 A couple of questions. I'm sorry. I didn't see
8 this addressed in the paper, and I don't think you covered
9 this, but when we talk about utilization management, can we
10 remind ourselves what we're talking about?

11 MR. PARK: Sure. That is prior authorization,
12 which would require the beneficiary to get approval from
13 either the state Medicaid program or the managed care plan
14 in order to fulfill the prescription, step therapy which
15 may require the use of a lower cost or generic version
16 first before having permission to try a higher cost or a
17 non-preferred brand, as well as quantity limits, which may
18 restrict how many prescriptions or fills or pills you may
19 get at any particular time.

20 CHAIR THOMPSON: And are those the three UM
21 approaches states use, or are there more but --

22 MR. PARK: Those are kind of the three.

1 CHAIR THOMPSON: Those are the three most common?

2 MR. PARK: Yeah. Those are the three kind of
3 broad categories. When people talk about UM, that's kind
4 of what they're talking about.

5 CHAIR THOMPSON: So we're not including lock-in?

6 MR. PARK: That's correct -- well, in the sense
7 that, potentially if the lock-in is listed as a prior
8 authorization requirement, then potentially we would be
9 picking --

10 CHAIR THOMPSON: On the sense that you could go
11 to another pharmacy, but you have to get prior approval for
12 another pharmacy?

13 MR. PARK: Right.

14 CHAIR THOMPSON: Okay. And so the next phase,
15 will we be able to distinguish among those categories when
16 we do the next phase of analysis, and do you think that
17 matters?

18 MR. PARK: In terms of whether a drug had to be
19 authorized or --

20 CHAIR THOMPSON: A quantity limit versus a prior
21 authorization --

22 MR. PARK: I don't think we'll be able to

1 determine that from the data that we'll be using to
2 determine the utilization because I don't think we'll have
3 all of the claim information as to whether it had some kind
4 of edit or anything like that. So I don't think we would
5 be able to determine like a prior authorization had a
6 greater effect on utilization than step therapy or anything
7 to that degree or whether that particular person was
8 affected by those tools.

9 CHAIR THOMPSON: Okay. So I'm going to ask a
10 broad question that you probably cannot answer, but I'll
11 ask it, anyway, which is -- so I look at this and say,
12 well, is it better to have broad coverage and a lot of
13 utilization management, or is it better to have narrow
14 coverage and less utilization management? And better from
15 the standpoint of cost control, better from the standpoint
16 of access and meeting the needs of beneficiaries. Any
17 thoughts on that?

18 MR. PARK: Well --

19 CHAIR THOMPSON: Are we going to be able to pick
20 that apart in any fashion?

21 MR. PARK: I think, you know, this is one area
22 where it may ultimately depend on the drug and the class as

1 to whether that's a better situation. Certainly if it's
2 very few drugs in a class and they're kind of significantly
3 different in terms of, you know, the treatment for various
4 conditions or like the severity of various conditions, it
5 may be better to have broader access to all of the various
6 treatments available in that particular class. Even though
7 they're restricted, you still have a chance to get the drug
8 that may be best for you.

9 In a more traditional class, such as, you know,
10 the cholesterol drugs like statins where there may not be
11 significant differences among all the choices right now, it
12 may not matter as much as to whether it was unrestricted
13 coverage -- you know, it may be better to have unrestricted
14 coverage, you just get whatever you want, versus having a
15 selection of ten of the ten versus seven of the ten. So I
16 think it kind of depends probably on the situation as to
17 whether one of those would be preferable or not.

18 CHAIR THOMPSON: And the nature of these
19 interventions matters, does it not? So I could see how
20 some of these interventions may be more science and data-
21 based and others not when it comes to especially UM
22 practices and maybe even coverage decisions, but how are we

1 going to think about that? You know, there's certain --
2 what you have to do to meet the requirements of a prior
3 authorization program can vary substantially from one payer
4 to another payer or one state to another state, and yet
5 they would all show up in our analysis as, well, there's
6 prior authorization, but the experience of providers and
7 beneficiaries and the degree to which people -- I mean,
8 we're going to get at some of that kind of by proxy by
9 looking at utilization, you think?

10 MR. PARK: I think broadly speaking we'll use
11 utilization as a bit of a proxy to try to get a sense of
12 how restrictiveness --

13 CHAIR THOMPSON: How wide or narrow --

14 MR. PARK: -- or, you know, how much it kind of
15 shifted behavior. We do have some information within the
16 formulary data about particular notes in terms of, you
17 know, what was required for prior authorization. We
18 attempted to look at some of that for a couple of drugs,
19 and one thing that was difficult is, you know, across
20 several thousands of formularies, how do you kind of
21 summarize that information and classify it as to, you know,
22 make a good comparison and that was requiring a lot of

1 work. So, you know, we kind of limited it to a couple of
2 drugs, but we could certainly, if there are drugs that the
3 Commission is particularly interested in, try to explore a
4 little bit more on a qualitative level as to what the
5 restrictiveness was for those particular drugs.

6 CHAIR THOMPSON: Yeah, I think it's possible that
7 we could find ourselves wanting to dive in a little bit
8 just because at a high level I think it becomes very
9 interesting, but it becomes very hard to interpret because
10 there is so much meaningful variation in those terms and
11 whether or not we're really comparing apples to apples or
12 apples to oranges.

13 And I just want to remind ourselves, we got into
14 this because we were asking ourselves whether the
15 requirements of the drug rebate program created constraints
16 on states that were significantly different than other
17 payers were experiencing. And am I right in concluding the
18 results of this analysis is they may be going at it
19 slightly differently, but they're still actively managing -
20 - they're effectively actively managing their formularies
21 in the way that other --

22 MR. PARK: Yeah, I think it's a bit of a mixed

1 picture, and I think it kind of reflects the statements we
2 heard in our December panel that for a lot of the drugs and
3 a lot of the classes, Medicaid does a pretty good job, and
4 they're kind of managing the use similar to other payers.
5 Some of these more specialty classes where maybe it's like
6 the first drug in the class or it's a unique situation
7 where they don't have as many tools because they can't, you
8 know, exclude coverage and if there's a question as to
9 whether this drug is truly effective, you know, Medicaid
10 programs may want to be more restrictive or not cover the
11 drug, where commercial plans can actually do so, you know,
12 Medicaid doesn't have quite the flexibility to do so.

13 CHAIR THOMPSON: It's just it's easier in those
14 situations to just exclude it as opposed to develop a UM
15 approach to managing it.

16 MR. PARK: Right. So I think, you know, there
17 are probably a few cases where Medicaid may be
18 significantly limited compared to commercial plans, but
19 kind of broadly speaking, across everything, they're not,
20 you know, that different.

21 CHAIR THOMPSON: Okay. Thank you.

22 All right. So I saw Kit, Brian, Chuck, Toby.

1 Fred, did I see you? No? I imagined that. Okay. Kit.

2 COMMISSIONER GORTON: So with regards to the
3 questions you asked, Penny, I think it's also important to
4 keep in mind what the cost of the drug is, right? Because
5 there's a return on investment in utilization management.
6 It costs money to hire nurses and doctors and pharmacists
7 and coders and all the others to set these things up. And
8 so you pick your place. But we know that Medicaid programs
9 find their administrative budgets often capped, so that's a
10 level of less flexibility -- if I'm running a Medicaid
11 program, I simply can only act so fast and I can only do so
12 many and I can only grow my budget so much. That's part of
13 why the hepatitis C drugs were so devastating. You just
14 couldn't put enough in place fast enough, and the no 180
15 days. So I think you need to think about that.

16 The gloss I want to give on what Chris said about
17 the three major categories of UM, there are degrees, right?
18 So there are flashing yellow lights, and there are speed
19 humps, and there are stop signs, and there are red lights,
20 and then there are, you know, barricades. And where you
21 throw those things up depends on how common the condition
22 is, how expensive the drug is. Exondys is a great example;

1 Kalydeco for kids with cystic fibrosis. And so all that, I
2 think -- and Chris will correct me if I'm wrong, but I
3 think at the level of administrative claims data for the
4 pharmacy benefit, we're going to have trouble getting to
5 the level of clarity, and I think part of what you did in
6 the Phase 1 study was say we can't study all drugs all the
7 time. I think what you may want to do is focus down even
8 further, at least on some classes of drugs, and on periods
9 of time, right?

10 So we now have enough history with hepatitis C
11 that you can look at what happened when Sovaldi came on the
12 market -- well, you can look at what the baseline was when
13 we were dealing with PEG Interferon and that whole mess.
14 And then Sovaldi comes on the market, and you can look at
15 what happens there and compare that to commercial versus
16 the plans.

17 And then the other drugs come on the market, and
18 things all shift, right? So there were huge changes in the
19 formularies over the course of 18 to 24 months, and I think
20 that may illuminate where the commercial payers, where the
21 Part D carriers had flexibility that the Medicaid programs
22 didn't have. Ultimately, I think the Medicaid programs

1 probably for most things in most places get to the same
2 place. Pediatric drugs, particularly in the post-OBRA '89
3 environment of expanded EPSDT, a little trickier because
4 it's sort of hard to say what's medically necessary and
5 what's not. And to the extent you have drugs like Kalydeco
6 which are pointed at a pediatric population, that can be an
7 issue. But I think that -- DMARD is another good example.
8 You know, I think if we hone in on a couple three sets of
9 very expensive drugs that came out and launched over time -
10 - statins isn't going to tell you anything. If you could
11 go back and look at statins in the '80s, that might tell
12 you something because that's when they -- but now they're
13 all pretty cheap, and they all work pretty much the same.
14 And so I wouldn't invest a whole lot of energy trying to
15 tease that out. But I would think about emerging therapy,
16 because I think from my point of view, emerging therapy is
17 one of the places where Medicaid has the least cover.

18 CHAIR THOMPSON: Where a commercial payer may
19 wait.

20 COMMISSIONER GORTON: Yes.

21 CHAIR THOMPSON: But Medicaid cannot.

22 COMMISSIONER GORTON: Medicaid cannot.

1 CHAIR THOMPSON: And then may not have the
2 evidence and the capacity to get on top of it from --

3 COMMISSIONER GORTON: Correct. And if you're in
4 a state that has a big, you know, biopharma sector or
5 that's a big part of the economy, there are political
6 pressures that come in there. And so, you know, I think we
7 might learn more by focusing on a couple of case studies --
8 not that we shouldn't do the other work because I think the
9 other work is important. But I think where you're going to
10 really tease out the substantive difference is at the
11 points of inflection.

12 CHAIR THOMPSON: Thank you, Kit. Brian, Chuck,
13 Toby, Sheldon.

14 COMMISSIONER BURWELL: So my question was pretty
15 much the same as Penny's in terms of broader kind of where
16 are we going from a policy perspective on this. The way
17 I'm hearing this analysis is that we're looking at the
18 Faustian deal between Medicaid and drug companies around
19 the drug rebate that you have to cover all drugs on your
20 formularies. And this analysis looked at that and said,
21 okay, what is the implication of that deal relative to
22 commercial and Medicare? And if I'm right, it's not a

1 whole lot because Medicaid can use these other tools to
2 control --

3 MR. PARK: That's correct. I think, you know, in
4 terms of the ability to put prior authorization and other
5 tools -- and use other tools, it's not that different. How
6 those ultimately play out as to whether, you know, those
7 prior authorizations are --

8 COMMISSIONER BURWELL: Yeah, this is just a
9 process analysis. So Phase 2 is going to be what's the
10 actual impact on utilization.

11 MR. PARK: Right

12 COMMISSIONER BURWELL: So do we feel that we have
13 the ability to actually look at that.

14 MR. PARK: Yes, we're going to --

15 COMMISSIONER BURWELL: Like because it's specific
16 to the specific utilization management control that is
17 utilized, right?

18 MR. PARK: Right. We won't be able to, like,
19 assign, you know, quantify the effect of prior
20 authorization per se, but I think we will be able to say,
21 you know, for this drug in this class, like all three
22 payers kind of assigned some utilization management to it,

1 you know, what was the effect? Did that really drive
2 behavior? Did the utilization of that drug for Medicaid
3 differ from commercial or Part D?

4 COMMISSIONER BURWELL: You're going to control
5 for population type?

6 MR. PARK: We will have some medical information
7 to a certain extent because we are looking -- we will look
8 at specific classes that does control a little bit for
9 differences in populations in that they all have a
10 particular condition that needs to be treated with this
11 drug, so to treat that particular condition, are they using
12 a more expensive drug or, you know, less expensive drug?
13 Are they using generics versus brand? Things like that.
14 You know, we'll be able to look at that. But we won't
15 necessarily be able to necessarily tease apart all the
16 comorbidities that may be affecting these beneficiaries.

17 COMMISSIONER BURWELL: Okay. Thanks.

18 CHAIR THOMPSON: We'll let the adjective
19 "Faustian" pass without comment. Chuck.

20 COMMISSIONER MILLIGAN: Nice job, Chris. One
21 quick comment, and then I think I want to sort of suggest
22 two areas of focus.

1 It seems to me that one other distinction that
2 could exist but my gut is it's not is how easy or hard the
3 exceptions process is for patients to get some drug that
4 isn't preferred or on a formulary. But to me that's kind
5 of a minor aside.

6 I think in terms of advancing our work about the
7 Medicaid Drug Rebate Act, to me there are two things I
8 would really want to see some focus on, one of which
9 several folks have touched on is this 180-day. I do think
10 if we want to weigh in on that more strongly than we have
11 historically, we need to understand better the distinction
12 between Medicaid, Medicare, and commercial about what
13 happens in that 180 days, you know, what the implications
14 to patients, all of that kind of stuff. So I think that
15 that -- and I think Darin, as I recall one of the meetings,
16 was, you know, that states should have the opportunity to
17 evaluate is this new drug to market an improvement of
18 what's already available or not if there's a big price
19 distinction and all that stuff. So I think the 180-day
20 thing and what those other payers do during that period and
21 how does that change a Medicaid decision versus theirs, I
22 think that's an important area for us to get some focus on.

1 And to me, the second one -- and I don't think
2 we've mentioned it in this discussion so far -- is whether
3 the drug rebate or the rebate provisions of Medicaid
4 distort what drugs end up on the PDL because of how the
5 rebate provisions interplay with the drugs that are on the
6 PDL. And so in the determination for commercial and
7 Medicare about -- or MCOs, what drugs end up in a formulary
8 or preferred and how the rebates are obtained by those
9 other purchasers versus Medicaid, and Medicaid kind of
10 working inside of the Drug Rebate Act, does it -- does the
11 rebate piece of it influence the development of the PDL and
12 how is that distorted or not? Because I think that there's
13 -- that will then have implications to whether and how we
14 weigh in on the rebate rules themselves that Rick has
15 walked us through a few times.

16 CHAIR THOMPSON: Good. Thank you, Chuck. Toby.

17 COMMISSIONER DOUGLAS: Yeah, my question is on
18 this last piece on just utilization and then the net of
19 rebates, bringing the full picture. And I think this gets
20 to that question I asked before, so I don't know where we
21 are on getting to it, but I don't know how we really truly
22 understand the implications of the different formularies

1 without taking in what's the net cost compared to what
2 Medicare or others -- because you could have more on the
3 PDL, and some might be more expensive, but in sum, given
4 the flexibility that Medicaid has and the rebates, that
5 it's still better off.

6 MR. PARK: Right. Yes, that's certainly going to
7 be a limitation of this analysis in that we won't be able
8 to get drug-specific rebate information to really
9 understand what the --

10 COMMISSIONER DOUGLAS: Where are we on -- was
11 that -- what happened?

12 MR. PARK: There was some language introduced
13 that would give both MedPAC and MACPAC access to the rebate
14 information, but that hasn't passed, you know, yet. So
15 it's still to be determined when and whether we'll ever get
16 access to that specific information.

17 COMMISSIONER DOUGLAS: Thank you.

18 CHAIR THOMPSON: Sheldon.

19 COMMISSIONER RETCHIN: I would just -- I am
20 interested -- and maybe it was Kit that just raised it
21 about looking backwards on the hepatitis C dissemination of
22 treatment, just to point out, though, that even those that

1 we've become comfortable with that have no price
2 differentials like statins, the PCSK9 new drug is --
3 whereas, the statins are an average of about \$1,100 a year,
4 it costs \$14,000 a year and is enjoying -- or experiencing
5 an increase in prescription rates. I'd be interested in
6 knowing actually. I assume that because it had rapid
7 approval that it's also on the -- part of the Medicaid?

8 MR. PARK: Yeah, Medicaid does have to cover the
9 PCSK9 inhibitors. I'm pretty sure we included that as part
10 of our analysis, but I don't know the specifics on that
11 right now. In terms of doing kind of like a time series
12 for a particular drug or class, that is something we're
13 thinking about for Phase 2 to see if we can identify a few
14 drugs that maybe were introduced in the market within the
15 time period of data that we have. Unfortunately, we don't
16 have formulary information that goes back far enough on,
17 like, the hepatitis C drugs, but there may be a few
18 particular drugs or classes where, you know, a new drug was
19 introduced in 2017 where we have our data that we can kind
20 of look for a few months after it came to market to see
21 kind of what the formulary differences and utilization
22 differences were.

1 CHAIR THOMPSON: Any other Commissioner comments?

2 [No response.]

3 CHAIR THOMPSON: Chris, this is excellent work.

4 I think the challenge is, you know, we do have some
5 practical limitations on data and you can't analyze the
6 world for us, and so I think I hear, you know, to the
7 extent that we can dive down into some things and really
8 sort of pull apart what's inside of what we're looking at,
9 I think that would be helpful.

10 MR. PARK: Okay.

11 CHAIR THOMPSON: And let me ask for public
12 comments.

13 EXECUTIVE DIRECTOR SCHWARTZ: Can I just add
14 something quickly? I just wanted to mention for
15 Commissioners, particularly since the issue around the
16 grace period came up, we haven't abandoned that. We're
17 just sort of putting it on a hold for a while. We've got a
18 whole bunch of things all kind of going at the same time
19 that are not all coming back to you tied up with a bow. We
20 are going to have a panel at the December meeting with some
21 state folks talking about some innovative things that
22 they're doing. And so, you know, at some point in the

1 future, all these pieces will start coming back together
2 again. Right now we're very much exploring a lot of
3 different ways --

4 CHAIR THOMPSON: Surrounding the issue.

5 EXECUTIVE DIRECTOR SCHWARTZ: Yes, we are
6 overwhelming you with random things.

7 CHAIR THOMPSON: Good. Thank you for that.

8 Any public comments?

9 **### PUBLIC COMMENT**

10 * [No response.]

11 CHAIR THOMPSON: And thank you, Chris, and that's
12 the end of our agenda today, and we will see everyone
13 tomorrow. We're adjourned.

14 * [Whereupon, at 3:42 p.m., the meeting was
15 recessed, to reconvene at 9:00 a.m. on Friday, October 26,
16 2018.]



PUBLIC MEETING

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

Friday, October 26, 2018
9:05 a.m.

COMMISSIONERS PRESENT:

PENNY THOMPSON, MPA, Chair
STACEY LAMPKIN, FSA, MAAA, MPA, Vice Chair
MELANIE BELLA, MBA
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
CHARLES MILLIGAN, JD, MPH
SHELDON RETCHIN, MD, MSPH
WILLIAM SCANLON, PhD
ALAN WEIL, JD, MPP
KATHY WENO, DDS, JD

ANNE L. SCHWARTZ, PhD, Executive Director

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P R O C E E D I N G S

[9:05 a.m.]

1
2
3 CHAIR THOMPSON: Okay. We'll go ahead and close
4 the doors and get started. Good morning, everyone, and
5 welcome to day two of our October meeting. We're very
6 pleased to kick off this morning with a couple of very
7 experienced and insightful state leaders who will help us
8 understand the world that we're living in today with
9 respect to dual eligibles.

10 So I'm going to let Kirstin kick us off and do
11 the introductions.

12 **### STATE EXPERIENCES INTEGRATING CARE FOR DUALY**
13 **ELIGIBLE BENEFICIARIES: PANEL ON STATE**
14 **PERSPECTIVES**

15 * MS. BLOM: Thank you, Penny. Good morning,
16 Commissioners.

17 So our first couple of sessions today are going
18 to be focused on integrating Medicare and Medicaid coverage
19 for duals. This is a topic of interest for the
20 Commissioners and an area of focus for us as staff. We
21 have work under way on enrollment and retention in the
22 duals demos and on care coordination.

1 We have also been closely monitoring federal
2 legislation and policy changes, including things like the
3 D-SNP permanency in the Bipartisan Budget Act passed
4 earlier this year.

5 But we've also been tracking state actions.
6 States are working to integrate care for their dually
7 eligible populations, even as policies at the federal level
8 are still taking shape.

9 The purpose of today's panel is to give you guys
10 the opportunity to engage directly with state officials who
11 are working on integrated care and states recognized as
12 leaders in this field.

13 We have here today officials from Arizona and
14 Virginia to speak to you guys about their experiences
15 integrating care for their populations and then the
16 successes and challenges that they have faced.

17 First, we will hear from Mr. Tom Betlach. Mr.
18 Betlach is the director of Arizona's Health Care Cost
19 Containment system, a role that he's been in since 2009.
20 He reports to the governor on the program, which currently
21 provides Medicaid coverage to 1.9 million Arizonans at an
22 annual cost of \$12 billion.

1 Arizona has decades of experience with managed
2 long-term services and supports. The state did not
3 participate in the Financial Alignment Initiative and
4 instead aligned its existing MLTSS program with D-SNPs.

5 Under Mr. Betlach's leadership, Arizona now leads
6 the nation with the highest percentage of duals aligned in
7 the same health plan for their Medicare and Medicaid
8 benefits, outside of demonstration authority.

9 Mr. Betlach is the former president of the
10 National Association of Medicaid Directors. He serves on
11 the board of the National Committee for Quality Assurance
12 and is a member of CBO's panel of health advisors.

13 Our second panelist is Ms. Karen Kimsey. Ms.
14 Kimsey is the chief deputy for Virginia's Department of
15 Medical Assistance Services. She oversees the daily
16 operations of the agency and works with the director, Dr.
17 Jennifer Lee, to provide leadership and management to all
18 DMAS programs, including the state's Medicaid expansion of
19 an estimated 400,000 newly eligible adults, which will be
20 effective on January 1.

21 Ms. Kimsey has over 23 years of experience at
22 Virginia's Medicaid program, with an emphasis on

1 populations in need of LTSS and behavioral health services.
2 Prior to her appointment as chief deputy, Ms. Kimsey was
3 Virginia's deputy director of Complex Care and Services.
4 Her responsibilities included oversight of Virginia's
5 Financial Alignment Initiative demonstration called
6 Commonwealth Coordinated Care, and under her leadership,
7 the state transitioned from that regional demonstration,
8 which ended this past year, to the current statewide MLTSS
9 program aligned with D-SNPs called Commonwealth Coordinated
10 Care Plus, a program that now covers approximately 210,000
11 individuals with complex care needs.

12 Ms. Kimsey also led the development of the
13 Addiction Recovery and Treatment Services, or ARTS program,
14 in Virginia, which was implemented in 2017 to address the
15 opioid epidemic.

16 Each of our panelists will give a brief
17 presentation, and then we'll use the majority of the time
18 allotted for today's session for conversation between you
19 all, the Commissioners, and the panelists.

20 Following the panel session and the break, we'll
21 talk about the direction of the Commission's work on
22 integrated care for duals.

1 And now I'd like to turn it over to Mr. Betlach
2 to tell us about his experiences in Arizona.

3 * MR. BETLACH: Thank you, Kirstin.

4 Good morning, everybody. It's a pleasure to be
5 here today to talk with you about duals and celebrate
6 Commission Gordon's birthday. So I'm happy to be here.

7 Just a quick overview on Arizona. As was
8 mentioned, we've had mandatory managed care in place for
9 decades. The population excluded from that is the American
10 Indian population. We are an expansion state, as was
11 mentioned. We cover about 27 percent of the state's
12 population. We've got 152,000 duals, and I'll talk quite a
13 bit in my discussion around alignment. For us, alignment
14 means that those individuals are enrolled with the same
15 organization, both within the Medicaid managed care product
16 and a dual special needs product. So for us, that's
17 alignment.

18 And we have three different lines of business in
19 which we've been pursuing strategies to build that
20 alignment. So the first are individuals with developmental
21 disabilities. We have 7,100 individuals with a 61 percent
22 alignment, 25,000 members that are in a long-term care

1 program for the elderly and physically disabled, 32 percent
2 alignment, 120,000 individuals that are not in our long-
3 term care program, and there's a 48 percent alignment. So,
4 overall, we're at 70,000 members aligned, about 46 percent
5 of our duals population.

6 I think as we start this conversation, it's
7 important to acknowledge the progress that's been made in
8 this decade around dual eligible members and really the
9 different systems that have evolved in terms of the
10 partnership between the state and the federal government,
11 and I would put out that there's been more progress in this
12 decade than there was from the 1965 to 2010 period around
13 dual eligible members.

14 And I'd really credit four different things in
15 terms of that progress that's been made. The first is the
16 federal structure that was mentioned in terms of the
17 permanent authorization of D-SNPs, the waiver authority,
18 and the demonstration programs that were led out of the
19 duals office.

20 The second is the evolution of a delivery system
21 at the state level, where states have gone to Medicaid
22 managed care for long-term services and supports and really

1 created a platform by which you can attempt strategies
2 around alignment and to look and identify strategies for
3 the dual eligible population.

4 The third is just a willingness to partner
5 between the federal government and state government.

6 And fourth, it's been really carried out by a
7 variety of resources that are now available to support
8 states because this is really difficult work, and we've had
9 a lot of resources available from the duals office. We've
10 had the National Association of Medicaid Directors heavily
11 involved in this topic, the Center for Health Care
12 Strategies, the Integrated Care Resource Center, so a lot
13 of different types of support out there for states in terms
14 of this journey.

15 I'm going to highlight eight different
16 strategies, initiatives that have really helped us in
17 Arizona in terms of our progress.

18 The first is the commitment from the leadership
19 of the organization. When I came into Medicaid, the first
20 project that I worked on coming out of the budget office
21 was the Medicare Part D implementation, Medicare
22 Modernization Act. I'd sit in these meetings with our

1 team, and I had a very difficult time understanding who
2 would ever create a system in which we would take some of
3 the most complex individuals and have them served by two
4 different programs, Medicare and Medicaid, where we were
5 then trying to figure out how to split up the benefit and
6 transition prescription drugs over to the Medicare benefit
7 at that point in time. And it just perplexed me and
8 really, I think, created the will and the want to be able
9 to do something different as it related to serving these
10 individuals, and so we've spent the last decade-plus really
11 working on strategies to do that.

12 The second strategy that we've deployed is we've
13 had staff specifically assigned to the Medicare side of the
14 house. So we've had resources on board that we've been
15 willing to pay for as an organization that do things like
16 work on MIPPA agreements, comment on the regulations that
17 have been put forward in terms of stars and making stars
18 recognizes the uniqueness of D-SNP programs, work with the
19 plans, who ultimately end up employing all these
20 individuals that we hire to take on this role, work with
21 CMS, work with other states.

22 We are talking now with the State of Hawaii about

1 sharing this resource that we have for their efforts to
2 educate our leadership team within the organization, and
3 really one of the most important functions is to write our
4 managed care contract language. So Medicaid is such a
5 specialized unique program, and oftentimes, it's difficult
6 for Medicaid agencies to be able to fully appreciate all
7 the complexities of that, but to have that resource on
8 board has been very helpful for us.

9 The third strategy is that we have used our
10 regulatory position to mandate for our managed care
11 organizations. So we require that all of our Medicaid
12 managed care plans be dual eligible special needs plans.
13 That's if they want to do business with us, they have to be
14 a dual eligible special needs plan.

15 We require that in the Arizona marketplace, if
16 you're going to be a dual eligible special needs plan where
17 we will sign a MIPPA agreement, you have to have a contract
18 with the Medicaid agency to deliver Medicaid services. So
19 we let that be known a couple years in advance so that
20 folks can make business decisions in terms of whether or
21 not they wanted to bid on a Medicaid product, but we took
22 that stance.

1 The third is we created a statutory structure,
2 where if you want to create a dual eligible special needs
3 plan in the Arizona marketplace, you don't have to go
4 through the Department of Insurance. We're the regulator
5 of the Medicaid plans, and you can just come to us and
6 create that D-SNP within the State of Arizona, so that
7 helped streamline some of that regulatory oversight for
8 those plans.

9 The fourth area is we leverage our authority and
10 our ability to mandate around trying to build alignment.
11 So there's been a variety of different tools that have been
12 created by the federal government to help build those
13 alignment numbers. One was seamless enrollment, and so
14 that was authority that existed previously. And we had all
15 of our plans get enrolled, and seamless enrollment is for
16 an individual who is currently served by a Medicaid plan,
17 but becoming Medicare-eligible as a result of either aging
18 into the program or also as a result of the two-year window
19 around disability. They are seamlessly enrolled into that
20 dual eligible special needs plan of their Medicaid managed
21 care plan.

22 They have the ability to opt out at the front

1 end. They can opt out afterwards, but we've had tremendous
2 success with this in terms of helping to build our
3 alignment. We also worked with CMS so that as they rewrote
4 the regulations around this, we gave them the information
5 in terms of the importance around this for dual eligible
6 populations and the success that we've had in terms of
7 overall retention.

8 So, for example, under the old seamless
9 conversion, over the course of a little under a year, we
10 had 4,427 individuals enrolled, and less than 11 percent
11 opted out. In the first three quarters of 2018, we've had
12 3,300 individuals enrolled and about a 92.9 percent
13 retention rate, so very strong retention rates in terms of
14 these types of tools to help build that alignment.

15 The other strategy that we've pursued is if we
16 have in the past seen individuals enrolled on a Medicare
17 side for a D-SNP plan but not been enrolled in the same
18 Medicaid plan, we've then aligned on the Medicaid side with
19 their Medicare enrollment. So we've said to those
20 individuals, "We see that you are not aligned. We would
21 like to align you. We are going to move you on the
22 Medicaid side. You have the ability to stay in your

1 existing plan," and again, we've been very successful in
2 terms of using that strategy.

3 We've leveraged this alignment then to drive more
4 value-based purchasing. So we require our managed care
5 organizations to have a certain percent of their spend in
6 value-based arrangements. We used the Learning and Action
7 Network's four different categories, and so we extended
8 that to their Medicare D-SNP spend. And it's just a way
9 for us to try to continue to build a value-based purchasing
10 system through that alignment strategy.

11 The other strategy that we use is we enforce as a
12 regulator. So we've had plans, for example, are able to
13 expand on their Medicaid side, and they weren't able to
14 bring up their D-SNP in that area in time. And so we have
15 sanctioned that plan. We have sanctioned plans if they're
16 not at three stars because if you're not a three-star plan
17 on the Medicare side, then you're not able to do default
18 enrollment, which is now the same as seamless conversion.

19 So it's important for that Medicaid agency to use
20 all the levers that you can to really enforce your
21 strategies around overall alignment.

22 The final area I'll mention is we leverage data

1 sharing. So we get information from the federal government
2 in terms of our dual eligibles that may not be aligned. We
3 share that back out to our Medicaid managed care
4 organizations. We call it blind-spot data, and it's just
5 additional information. It's not necessarily timely in
6 terms of "I'm going to take action on that information
7 immediately," but it helps build the overall analytics in
8 terms of what that population or member looks like in terms
9 of services that they're receiving outside the unaligned
10 individuals within our organization.

11 So I think it's important to recognize that we do
12 all this, despite knowing if it is done well, all of the
13 benefits or the majority of the benefits accrue from a
14 financial perspective to Medicare. Obviously, there's
15 better outcomes for the individuals that are being served.
16 We've seen that in the dual demonstration evaluations that
17 have come out to date.

18 So, for example, in Minnesota that leverages that
19 D-SNP model, similar to Arizona, they saw over a 40 percent
20 lower use of inpatient days, 40 percent lower readmissions,
21 higher use of home and community-based services. So I
22 think it's important to recognize that states are heading

1 down this path, and they're doing it obviously with good
2 intentions of better serving the population, but at the end
3 of the day, Medicare is the program that really benefits
4 from our efforts around building this type of alignment.

5 So just in closing, a few things I would like to
6 touch on in terms of areas of opportunities, where you all
7 may consider recommendations. The first is that when you
8 look back at the demonstrations -- and we sort of evaluated
9 the demonstrations and whether or not we wanted to do a
10 waiver, and we just felt D-SNP, given where we were at,
11 that we were already using D-SNPs, was the best path to go
12 moving forward.

13 But one of the great things about that time was
14 they pushed out grants to states to really evaluate what
15 strategies they want to pursue, and when you look at the
16 growth of managed long-term services and supports within
17 the Medicaid space, I think there's another opportunity to
18 reengage states because we've gone in the last decade from
19 just a handful of states having MLTSS to today there's
20 around 25 states.

21 So I think if the federal government were to
22 contemplate some ability to provide some start-up funds --

1 and I'm not talking about a ton of money, but to help fund
2 some strategy money for states, I think that that would be
3 meaningful because, at the end of the day, the federal
4 government is the one that's going to benefit the most in
5 terms of really pursuing optimal strategies.

6 The second along those same lines is if the state
7 is moving forward with a strategy and is successful, like I
8 would say Arizona has been, then there should be an ability
9 to continue to fund the infrastructure that's necessary to
10 do that, again, not talking a lot of money, but those
11 couple of positions that are necessary to really stay
12 engaged as it relates to that.

13 The third recommendation would be to enhance
14 programmatic FMAP for Medicaid duals for states when the
15 states are pursuing an alignment strategy and are
16 successful with that with higher-performing plans. So if
17 you have plans that are doing well, you are seeing the
18 outcomes that you desire, similar to what we did with Money
19 Follows the Person, where there was enhanced federal
20 participation made available to try and drive this system,
21 I think there's a real opportunity to leverage financial
22 alignments to help move processes along. So I would

1 encourage you all to think about that because, again, I
2 think the federal government really gets the ROI on those
3 types of investments through the savings that are generated
4 on the Medicare side.

5 Last but not least, I really think there needs to
6 be a longer-term solution in looking at recommendations
7 around how do we make a fundamental change for the dual
8 eligible population so that they are no longer served by
9 these two separate systems because nobody would sit here
10 today with 11 million of our most complex members and say,
11 "You know what? We need to serve them out of two separate
12 systems." We would come up with a singular approach in
13 terms of how to best serve that population, and I really
14 think it's time to give thought in terms of what that looks
15 like.

16 I will tell you the challenges within that are if
17 you look at a federal solution, the federal government does
18 not have the experience with long-term services and
19 supports and behavioral health that are critically
20 important to this population because it's not a homogeneous
21 population. There are all types of different subsets of
22 the population that exists within the dual population, and

1 so I would encourage you all to think about that.

2 So, with that, I will conclude my comments and
3 look forward to the conversation. Thank you.

4 * MS. KIMSEY: Okay. I think it's my turn. Good
5 morning, everyone. It's a pleasure to be here today to
6 talk with you about Virginia's experience with our dual
7 eligible, our FAD, our demonstration, Commonwealth
8 Coordinated Care, as well as our migration into our
9 mandatory product, which was outside of the demo. So, as
10 well, we serve 1.6 million people in the Medicaid program.

11 We are so excited to announce that we are going,
12 expanding to 400,000 individuals as of January 1. We have
13 all of our authorities in place, and we're ready to roll.
14 Enrollment begins next week. Just had to put the plug in
15 there for it.

16 [Laughter.]

17 MS. KIMSEY: It's just several years coming.

18 But we also serve about 110,000 dual eligible
19 individuals in our program, and I have to say that on the
20 experience related to our FAD, we are very excited to be a
21 part of our alignment demonstration, and credit to
22 Commissioner Bella for giving us the opportunity to do

1 that.

2 We were third out the gate. I think Ohio would
3 argue with us on that, but we really were.

4 [Laughter.]

5 MR. BETLACH: John is not here, so it doesn't
6 matter.

7 MS. KIMSEY: And so we had targeted -- and for
8 our pilot, we targeted adults, not children. We excluded
9 people with developmental disabilities, and we also looked
10 at people who used a very particular program of ours, our
11 Aged Disabled Waiver.

12 We also looked at our community well population,
13 people who have had serious mental illness or maybe even
14 addiction needs at the time, and so there are about 60,000
15 individuals in March of 2014 that we targeted. We had
16 about 30,000 individuals enrolled in the program. So
17 there's about 50 percent participation, and we were very
18 pleased with that.

19 One component of it that I think was challenging
20 for us and other states would tell you is the churn that we
21 had related to the ability of people to pop in and out on a
22 monthly basis, but our federal partners, I have to say,

1 CMS, the office was great. We did enjoy having the joint
2 contract with CMS and with the state to combine both
3 programs and be able to blend that rate, and the plans also
4 talked about that, that component as well. And so as issue
5 arose, we were working closely with them and more readily
6 with them on how to address that.

7 For example, they were in the process of allowing
8 us to lock in the Medicaid members to control the churn on
9 the Medicaid side, and we had three health plans who were
10 partnered with us in that particular program, but
11 unfortunately for us, we had state legislative
12 requirements. So we were already under our mandate that
13 started in 2011, way before the demonstration, to migrate
14 all populations into managed care by 2017.

15 So, by 2015, we were having to decide what we
16 were going to do, and we had a great learning experience
17 with the FAD, but we also knew that at that time, it's
18 still a demonstration. We weren't able to expand
19 populations to go statewide, and so that was the decision
20 for us to migrate out of the demonstration at the end of
21 our contract period, which was December of 2017, and move
22 into our mandatory program that covered over 210,000

1 individuals, and it was all inclusive in services as well.
2 And the demo did have certain exclusions for services which
3 we folded all those in. For example, hospice, and also,
4 behavioral health services were included in the demo, but
5 we also included them on the Medicaid program side as well.
6 So we did experience a churn but we would have had the
7 support of CMS to lock them in if we had remained in the
8 demo.

9 And also we needed to include more than dual-
10 eligible individuals, which was another component for us.
11 So, as I mentioned, half of the members that we serve now
12 in the mandatory program are our duals. So we had to go
13 statewide, cover other populations. We now include people
14 with developmental disabilities on their acute and primary
15 care needs. Eventually we will migrate the long-term care
16 services.

17 But one of the things that we learned, and we
18 learned this, some of the lessons. So we had, with the
19 FADs, and I'm sure you have heard about it or will hear it
20 with future pieces, is take your time, have plenty of time
21 to enroll into the program, to phase in and regional
22 processes related to that. That way it gives you the

1 opportunity to learn as you go, especially if you're a new
2 state to this.

3 And we weren't new to managed care. We had over
4 20 years of experience with our pregnant women and our
5 children and our aged, blind, disabled populations, but we
6 were new to long-term care, and so was the long-term care
7 system and behavioral health. And so the regional phased-
8 in process was very helpful on that end, because we were
9 able to make corrections as we moved.

10 Also, we learned this with our -- and we had a
11 lot of support. I'll echo what Tom was saying. At the
12 federal level we had support with CMS. We also had the
13 Center for Health Care Strategies and other partners that
14 helped us along the way in terms of how we moved into the
15 system and gave us the support with our stakeholders. I
16 cannot echo enough how much we have to be involved with our
17 stakeholders, meeting with them regularly, ongoing, those
18 individuals who receive the services, and their families,
19 as well as the providers who deliver it, and our health
20 plan partners.

21 So that was a very important process for us,
22 continuous, ongoing, and it did not end as soon as the

1 program launched. It's constant and that's very important.
2 And so when we actually made the decision to move to the
3 mandatory Medicaid product, with the D-SNP combo, and we do
4 require our six health plans that we have now, two of which
5 were in the FAD, they have to be D-SNPs. We gave them a
6 period of time to develop their D-SNP product and to come
7 into compliance with that, and that was as of January of
8 this year that they're starting off to do that.

9 And so we did see that important part, that even
10 if we were leaving the demo that we still wanted that
11 integration of care. We saw that as a critical component,
12 and ideally would have loved to have had a continued
13 contract with CMS on the FAD, similar to what Minnesota
14 has, but they were so busy bringing up other states at that
15 point. But they have committed to us that they are going
16 to work with us to look at that, a similar type of contract
17 related to that, and we're actually very excited about
18 that.

19 I also would like to mention, for our program, on
20 the Medicaid side in Virginia we do not have a strong
21 penetration rate. It's about 16 percent on the managed
22 care side for Medicaid. So we have -- you know, I would

1 say it's an opportunity more than a challenge for us, to
2 actually help people to understand and see what alignment
3 of these two programs can be for them and how it can help
4 them in their lives and coordinating that care.

5 And that was another big selling point for us in
6 managed care. You know, a lot of states go in saying
7 "we're going to save money" and for us it was we want to
8 better coordinate individuals' care and their experience to
9 help them navigate at a very fragmented system between both
10 Medicare and Medicaid. But also to bend the curve over
11 time, to have better predictability to the costs and see
12 where we can have those efficiencies. And we did see that
13 and we did witness that and experience that in our demo.
14 And so we also hope to have that happening in our program
15 that we have now.

16 So we are just a year out and we look to Tom and
17 his state and we also look to Tennessee and to
18 Massachusetts and other states, Minnesota, that have gone
19 before us, and now we're looking at New Jersey as well, to
20 how we keep moving forward, because now we have the
21 framework in place, and then how can we advance.

22 So right now we have the alignment for our

1 programs. We have 16,000 people who are aligned in the
2 program itself, and that's commensurate to our experience
3 right now in the Medicare scene. But we are eager to bring
4 it up to a much higher percentage that we're witnessing in
5 other sister states that have had more experience than we
6 have had at this point. So we are looking to default
7 enrollment, which we believe in, and we think will have a
8 positive experience for the beneficiary. And they also
9 have the choice to opt out if they wish not to stay with
10 the enrollment. So enrolling them into the D-SNP once they
11 become eligible for Medicare that aligns with their
12 Medicaid managed care plan. Also, we were looking at the
13 same process. We're going to explore that if somebody is
14 in a D-SNP offering to align them to the managed care plan
15 that serves them in that manner.

16 So those are the two avenues that we will be
17 moving toward in the future related to that.

18 Another piece, too, on the learning experience, I
19 was asked to tell you all some of the reasons why we
20 shifted over and then also some of our experiences related
21 to lessons learned are related to that, and how we are
22 doing things a little differently.

1 In terms of the care coordination piece, we
2 really believe in that and we've seen many wonderful
3 experiences where individuals benefitted from that. So we
4 believe that that happened and we have evidence that it's
5 happened and we have it very strongly written into our
6 contracts. And so I would agree with Tom. Your contract
7 is really everything, in terms of the leveraging and
8 control related to working with our partners in the health
9 plans, but also not only in the Medicaid side but on the
10 Medicare side with the MIPPA contracts, with the D-SNPs,
11 leveraging that.

12 We have expectations around requirements in terms
13 of the care coordination model. So we don't just say, hey,
14 we want you to advance care coordination and then leave it
15 up to them to figure it out. We have explicit requirements
16 related to our expectations for care coordination. We also
17 have ratios that we embedded in our programs. And so with
18 the dual alignment demonstration that we had we did not
19 have the ratios embedded in that, and so we had a varied
20 experience with our health plan partners related to what
21 they felt would be a proper ratio.

22 And so we had one experience at one point where

1 one plan had a 1-to-700 ratio, and we didn't agree that
2 that was going to work. When we actually did our new
3 procurement for the new program we set the ratios. We were
4 very open. We worked with our stakeholders who serve those
5 populations and represent those vulnerable populations and
6 said "what is a reasonable ratio?" and settled on that and
7 also with the plans, and that's embedded in our contract.
8 We look at that annually, but that's been very successful
9 for us.

10 Another thing that we did is we set up a care
11 management unit within our agency, whose only focus is to
12 ensure the successful implementation of care management
13 coordination within that system. And we actually train the
14 coordinators in the health plans and work with them every
15 week, over 500 of them, that we communicate with twice a
16 week. And so we continually educate and train them on the
17 programs, the trends and analysis that we're seeing related
18 to services, and what our beneficiary experiences are, and
19 relate that back to the coordinators.

20 And so we have a very strong connection with our
21 coordinators that way, and we wrote that into the contract
22 that we require that participation with the plans. And the

1 plans are very supportive of that. At first I would think
2 they were a little surprised to see that level of in-depth
3 involvement, but they support it now because they see that
4 the care coordinators are up-to-date on their information
5 related to the program, because the churn is significant
6 for them as well, as it is for any other program.

7 We also have a Medicare unit that has been
8 created in the agency because despite our best efforts in
9 the very beginning to say that was another program, we
10 realized we had to learn it very well and get very used to
11 services rendered in the Part D and the plans, and how to
12 better work and partner with our D-SNPs and actually
13 leverage that.

14 Another piece we're actually looking at, too, is
15 maybe migrating into a FIDE SNP, into the future, that that
16 will help as well.

17 So being open and transparent with our systems on
18 both sides, I think that was very critical for us. Being
19 very clear in expectations in our contracts. That is
20 something we've learned about. Also with the care
21 management side, just having explicit requirements related
22 to that, particularly related to ratios, and we're also

1 very involved with our encounter data, so that is a
2 critical, critical component. We actually built our
3 encounter system in house and started receiving the data
4 within the first month of the program going live, and we
5 are also receiving the Medicare data as well, and that's
6 another critical piece for consideration, and thank you to
7 CMS for providing that data for us, because we have insight
8 into the members and their experience.

9 As Tom echoed, we do not, in the new program that
10 we have, realize the savings. It is Medicare that realizes
11 the savings for our duals. And so the best thing we can do
12 at this point, though, is we still want to enhance and
13 coordinate that care related to that piece.

14 Another component, as well, for any new state
15 starting is just the new start-up with the programs and
16 having some grace as the program goes live in the beginning
17 related to providers enrolling, paying claims timely. All
18 those things are very critical components to that part, and
19 also to the members' experience.

20 So that is, you know, just a, I guess, brief
21 description of where we were and where we are at this time.

22 CHAIR THOMPSON: Thank you. Well, I know hands

1 are already going up. I know we've got a lot of folks that
2 want to jump in. So I see Chuck, I see Darin, I see Mel, I
3 see Kit, I see Sheldon, I see Brian, I see Toby. All
4 right. We'll see what we have left over from that. But I
5 get the prerogative, as the Chair, to ask a couple of
6 questions first.

7 I wanted to ask you both two questions. One is
8 both of you mentioned savings to Medicare. How mature do
9 you think is the data around where the savings are coming
10 from and to whom they are attributed? So if we're talking
11 about dividing a pie, do you both feel like we really do
12 know what that pie is?

13 MR. BETLACH: I would say that the best indicator
14 of that now are the third-party evaluations that are coming
15 back on the demos. Because they are third-party they are
16 doing a deep dive. There's a little bit of a lag,
17 obviously, in terms of being able to do that. But clearly
18 in terms of what we've seen in Minnesota and Washington,
19 and Melanie has a much better idea of where the other
20 states are. But they're all coming back, they're showing
21 savings, and they're showing savings, as we would all
22 expect, to changes in utilization that largely benefits the

1 Medicare side, with often times some increased expenditures
2 on the Medicaid side to achieve that -- home- and
3 community-based services, behavioral health, and other
4 things like that.

5 I mean, we'd love to see a third-party evaluation
6 done of Arizona now after we've been at this for many
7 years, and I don't know if your evaluation came back in or
8 not.

9 MS. KIMSEY: It has not.

10 MR. BETLACH: Okay.

11 MS. KIMSEY: But we also will be evaluating our
12 new program as well. So we have an external evaluator who
13 will be performing that. But I echo Tom's comment looking
14 at that.

15 CHAIR THOMPSON: Okay. And then just a second
16 question, so both of you talked about what alignment is to
17 you and where you are in terms of alignment, and the number
18 of things that you're doing to have achieved the numbers
19 that you're achieving now. Do you see -- what are the
20 major ways that you're now looking at to significantly
21 increase those numbers? You know, you continue working at
22 the things that you've been doing and you can expect some

1 incremental improvement, but do you feel like there are
2 some things that you might need additional authority for,
3 or that you could be doing, or plan to do that would create
4 a big jump in those alignment numbers?

5 MR. BETLACH: So clearly there's been
6 conversations around the ability to passively enroll
7 individuals beyond what the default enrollment allows for,
8 and I think that those are conversations that should
9 continue to happen, in terms of the ability to do that. I
10 think that there's obviously a lot of stakeholder
11 engagement that needs to be done around that, and
12 oftentimes stakeholder pushback on those types of
13 conversations.

14 But, you know, I think we've been -- it's been a
15 great partnership working with the duals office in terms of
16 getting that default enrollment for the duals population
17 and being able to stand that up with states. But so much
18 of this is just incremental strategies. It's hard to see
19 something that's really a big bang strategy.

20 I will tell you one of the challenges that we're
21 still wrestling with is. Oftentimes in the Medicaid space
22 we have competitive procurements and, you know, sometimes

1 that's statutory and I'm a believer in competition, but at
2 the same point in time it sometimes results in undoing the
3 work that you've achieved, in terms of alignment.

4 And so there is some authority that exists at the
5 federal level to help try and mitigate the impact of that.
6 We tried to leverage it this last time around. I think we
7 didn't do enough front-end planning to make sure all the
8 plans had their Medicare network in place when CMS had to
9 do the evaluation. So the next time we go through this
10 we're going to have to back up our timeline to recognize
11 that.

12 And so I think one of the major challenges states
13 face is you can spend all this time, you can get up in
14 terms of having high alignment and the next thing you know
15 the plans that had built that alignment are no longer
16 serving that region. So that's a major challenge in terms
17 of that.

18 MS. KIMSEY: And we would echo that as well, with
19 the passive enrollment. I think that is going to be a
20 critical component. And also just an educational piece. I
21 think I touched on that. And I would agree it's
22 incremental. But we have moved so much faster over the

1 last several years than we ever saw any movement, for many
2 years prior to that. And that also speaks to the support
3 at the federal level as well states engaging.

4 And so helping to continue to educate, provide
5 support to states to continue to migrate this way related
6 to that, in terms of -- and increasing the population, and
7 for us it's a matter of getting out and educating our
8 members, as well, and families and other key stakeholders,
9 to making sure that they see the benefit to the alignment.

10 MR. BETLACH: The blueprint is there. The
11 authority is there. I think, to a large extent, what is a
12 limiter is the ability of states to have resources to take
13 this on.

14 CHAIR THOMPSON: All right. So just a reminder,
15 we have Chuck, Darin, Melanie, Kit, Sheldon, Brian, Toby.
16 All right, so Chuck.

17 COMMISSIONER MILLIGAN: Feels like an auction.

18 [Laughter.]

19 COMMISSIONER MILLIGAN: I have two questions, the
20 first one for Tom and the second one for both of you. And
21 picking up on where Penny started, have you attempted, in
22 Arizona, to quantify the Medicare-related savings? Because

1 when you, in your recommendations to us, talked about
2 enhanced FMAP for states that do a dual alignment kind of
3 model, it's a more kind of -- seems to me more politically
4 feasible path than sort of taking on the Medicare trust
5 fund as a version of shared savings. But it would be
6 helpful to have a sense of what that enhanced FMAP would be
7 that would still produce savings for the federal government
8 and incent states.

9 So I'm curious if you've tried to quantify the
10 Medicare-related savings your program has produced.

11 MR. BETLACH: No, we haven't been able to. Would
12 love to. Came up with the recommendations on the airplane
13 on the way here last night, and they seemed like they were
14 plausible to me. But, you know, we'd love to do the third-
15 party evaluation. I think, to a large extent, I'm basing
16 that on what's transpired in terms of those evaluations
17 that have been done through the demo side of it, because,
18 again, those have the most rigor to them and I would hold
19 up. There's been some analysis done but it's been plan
20 sponsored and so you get a -- I think you need that third-
21 party evaluation.

22 COMMISSIONER MILLIGAN: Thank you. The second

1 question for both of you, in an early kind of dual-eligible
2 related panel several months back one of the issues on the
3 D-SNP side is that how CMS measures geo access in terms of
4 service area is very different than how Medicaid tends to
5 think of geo access. And I'll just give you the example in
6 New Mexico, where I work. We wanted to get our D-SNP into
7 many counties where we've just failed to meet the CMS test
8 because there just aren't providers. And CMS has not been
9 open on the Medicare side to aspects of non-emergency
10 medical transportation, getting people into more urban
11 service areas. They've not been very open to telehealth as
12 a workaround for geo access.

13 So I'm curious to the extent that you require
14 alignment with the D-SNP and to the extent that it's hard
15 sometimes on the Medicare side to go into some of those
16 rural and frontier counties, if you have any insight or
17 suggestions for us in terms of the federal advocacy piece
18 of that, or just insight in general, how you've tried to
19 address that within your markets around just your desire to
20 align into certain counties where meeting that federal geo
21 access standard is difficult.

22 MS. KIMSEY: Actually, I would like to speak to

1 our experience with the FAD. Our alignment demonstration
2 actually gave us that flexibility. So when we brought up
3 the issue with the geomapping, how it's different for the
4 populations in terms of the subspecialty providers, that's
5 where we were encountering problems, even related to the
6 FAD. And after we worked with our CMS partners they
7 actually opened that up and allowed it to be for the total
8 unique population that we were serving versus the total
9 Medicare population for the state.

10 And so I would invite that there be some
11 consideration for that to be on D-SNPs that are not in the
12 FADs. That could be of great benefit to other states.
13 Since they did open it up for that and the experience has
14 been positive, perhaps that would be an open avenue for
15 consideration.

16 We have not had that experience so far with our
17 D-SNPs but perhaps because we had such a small population
18 at this point. And so that has not been our experience,
19 but in the past they have given that, and so I would
20 encourage the Commission to talk with them and explore with
21 them is that an option.

22 MR. BETLACH: Arizona has many of the same

1 challenges New Mexico does. We have the advantage of
2 having only 15 counties from the purposes of evaluating.
3 We've tried to keep our regions large. It's one of those
4 areas where having that staff person has come in helpful
5 because they've worked hand in hand with the plans and gone
6 to Medicare around the exception process and talked about
7 exactly what you mentioned. NEMT is available for this
8 population and other things like that. There is that
9 exemption process that exists. It's sort of a black box,
10 not a lot of transparency around what that looks like. I
11 think we'd prefer to have a little bit more insight into,
12 you know, what that looks like. But, again, our staff
13 expertise to be able to help support the plans through that
14 process I think has come in handy on multiple occasions.

15 CHAIR THOMPSON: Great. Darin.

16 COMMISSIONER GORDON: Karen and Tom, thank you
17 both. I really appreciate your testimony.

18 You both touched on the staffing resources and
19 expertise that's needed, and while you guys have invested
20 into it, we've invested in it when I was in Tennessee. My
21 sense is that a lot of states are lacking some Medicare
22 expertise, and not even just the purest Medicare expert,

1 but also understanding all these different models and
2 approaches and paths they could potentially go down and the
3 lift of each one. Is that fair from your interactions with
4 your peers that that's --

5 MR. BETLACH: I agree with that completely. I
6 mean, we had a breakout session on this at our last
7 National Association of Medicaid Directors meeting. It was
8 very well attended, but you had the full continuum, and you
9 had a lot of folks down here. They had stood up managed
10 long-term services and supports on their Medicaid side.
11 They were trying to figure out a strategy for Medicare, but
12 they were just -- they didn't even know necessarily where
13 to start in terms of understanding D-SNP authority and they
14 had heard CMS might be taking on new demonstrations of
15 states that were interested or even the flexibility that
16 the administrators talked about. So that's why I mentioned
17 really as my first recommendation plow a little bit more
18 money back into this just to see if you can get states
19 willing to try and build some models that really leverage
20 the infrastructure that now exists that didn't exist a
21 decade ago.

22 COMMISSIONER GORDON: This question is for you,

1 Tom. I think, Karen, maybe it depends how long you've been
2 in the alignment side for whether or not this would be
3 appropriate, but if so, please weigh in as well. Have you
4 done anything on the rate development side in those
5 situations where you do have the alignment, you're
6 recognizing that there is the strength on the D-SNP side
7 and what's happening, that at least -- you know, I know
8 you're sitting more on the Medicaid side, too, but
9 conceptually it is functioning as a singular product,
10 albeit an imperfect one.

11 MR. BETLACH: Yeah, the actuaries, what they've
12 done is they've built separate rate cells for dual-eligible
13 individuals, and they're tracking that and looking at the
14 utilization. What they haven't done necessarily is then
15 build the Medicare data back on top of that. Typically
16 actuaries like to have three years' worth of information,
17 and we've only got about two now in terms of that
18 requirement where the plans have to submit the encounter
19 data so that it actually rests within our system.

20 So that's clearly something we can look to do in
21 the future, but -- I don't remember how long you all have
22 been capturing that data, but for us it's only been a

1 couple years, so we actually have enough experience now
2 where we can start doing that. But we have created the
3 separate rate cell, recognizing this is sort of a distinct
4 population.

5 MS. KIMSEY: We've done the same thing with the
6 rate cell, but we have not started to factor in the
7 Medicare expenses at that point.

8 I also just want to touch upon the -- having been
9 the state that started on a shoestring budget, we did not
10 receive additional grant support or funding related to how
11 we started. We just started it out of sheer will to move
12 into the MLTSS environment, and we just committed within
13 our agency it was a priority, and we literally shifted
14 positions into different components and just made it
15 happen.

16 And so as for our Medicare unit, when somebody
17 left in another area, we just took the position and flipped
18 it into something else because we defined it as a priority
19 for our agency. And so I would, you know, echo the need,
20 if there are additional funds available for states to move
21 that way, but it was for us a priority because it was a
22 priority for our administration and for our legislature,

1 but not every state has that type of support. And so in
2 order to get started, they will need those resources.

3 COMMISSIONER GORDON: I think only you, Karen,
4 had mentioned that you're contemplating the FIDE SNP.

5 MS. KIMSEY: Yes.

6 COMMISSIONER GORDON: And in our state, we had
7 one that was FIDE SNP; the other two were D-SNP, but in
8 other words moving to FIDE SNP. But I'm just curious,
9 what's your thought process there?

10 MS. KIMSEY: Well, we understand that it also
11 helps for better alignment related to the members and also
12 risk-adjusting to their actual cost needs.

13 COMMISSIONER GORDON: To the benefit of the plan.

14 MS. KIMSEY: Yes -- well, it's the benefit of the
15 plan, but as the plan benefits from that, we'll tie into
16 the contract for our requirements and expectations.

17 COMMISSIONER GORDON: Exactly. And that's,
18 again, the prior comment, which is, yes, they're two
19 different products, but you have forced a linkage there,
20 and so you have to think about them singularly.

21 MS. KIMSEY: You're right.

22 COMMISSIONER GORDON: But the benefit being that

1 that does then also, when you're looking back at rates,
2 that's another component that gets factored into that
3 overall map.

4 MS. KIMSEY: Right.

5 COMMISSIONER GORDON: Helpful. Thank you.

6 CHAIR THOMPSON: Melanie.

7 COMMISSIONER BELLA: Thank you both. You're
8 amazing. The work is amazing. A huge plug, by the way,
9 for building state capacity. I think the grants of
10 financial alignment states got were a million dollars. A
11 million dollars on a \$350 billion annual program is
12 nothing, and it did make a difference. So I have two
13 questions.

14 One, you guys are leading, Arizona, you and
15 Tennessee especially were leading the requirements for your
16 managed care plans to be D-SNPs

17 MR. BETLACH: Mm-hmm.

18 COMMISSIONER BELLA: And, you know, you guys are
19 doing the same, but the dual-eligible program is like a
20 constant game of whack-a-mole, right? So there are now a
21 lot of tools that states are using with their MIPPA
22 agreements to align that, but you see this emergence of

1 what everybody is calling look-alike plans. So these are
2 Medicare Advantage plans that are coming in, targeting only
3 duals that are not coming in as a D-SNP because they don't
4 want to have to get state or can't get state MIPPA
5 contracts or they don't want to do the model care
6 requirements. And I think rumor has it in 2019 36 states
7 will have these look-alikes.

8 So I'm curious of your thoughts about how should
9 the -- is there anything you want to say to the Commission
10 about how you're going to think about dealing with that?
11 Because it could significantly undermine alignment in
12 states. So that's one question.

13 The second question is just as you think about
14 being able to recognize, share the savings between both
15 payers, I don't think there's anything prohibiting you from
16 actually having some sort of shared savings agreement with
17 your plan, or that's a side agreement on the Medicare side.
18 And I'm curious if you're thinking about doing that and if
19 there's anything that you feel is a barrier to your ability
20 to do that that the Commission could contemplate.

21 MR. BETLACH: I'll take on the second question
22 first. I don't know that there's a barrier at the federal

1 level. I think there's probably a barrier for us at the
2 state level, and we would need state statutory authority to
3 do that. So I don't think that's necessarily a concern
4 within the Commission. I think it's something that we as
5 the Medicaid agency would have to go to the legislature.

6 On the first issue, you know, this is a new
7 concern for states. There's ever a continually evolving
8 marketplace as it relates to different models that are out
9 there, and so I think what we're going to do is evaluate to
10 see what happens within the Arizona marketplace, and if
11 necessary, ultimately try and identify if there's plans out
12 there that are targeting just our dual population, try to
13 create some parameters and limits around that. But we're
14 going to have to wait and see how that evolves. So we're
15 interested to see what comes online in 2019 and what type
16 of impact it has, and our strategy will have to be somewhat
17 reactive to what's in the marketplace, not proactive,
18 unfortunately. But it's a state-level issue as it relates
19 to the Commission. I mean, I think you're a more
20 knowledgeable person on this than I am in terms of what a
21 potential statutory structure may look like or even
22 something that CMS can do as it relates to trying to really

1 get back to the true purpose of what the D-SNPs are doing
2 in terms of really being able to build alignment and not
3 just sort of cherry-pick at that point in time.

4 MS. KIMSEY: I would echo that also. We're
5 seeing increased growth in I-SNPs as well, not just the MA
6 plans. So the I-SNPs are going in, and they're picking the
7 individuals off of the benefits, our programs for that, and
8 the state has no influence or control over those contracts
9 either, similar to MA. And so we've begun a national
10 conversation, alerting other states, hey are you seeing
11 this, not just for the MA but for the I-SNP growth. And
12 people are starting to pay attention to it as well, but
13 some of it also comes to the marketing strategies as we
14 have no control over or little control over. We can work
15 with our D-SNPs and control their marketing strategies, but
16 not the others. And so that I think would be an
17 interesting area to also target.

18 MR. BETLACH: Well, and I think there's clearly
19 an opportunity there for the federal government to address
20 that.

21 MS. KIMSEY: Absolutely.

22 MR. BETLACH: I think when we look at who's in an

1 institution, we know that two-thirds of the time Medicaid's
2 the payer involved there. And so if you have an I-SNP, it
3 seems to me there should be some state role in that knowing
4 that Medicaid's going to be part of the population being
5 served.

6 MS. KIMSEY: I agree. I think that an I-SNP
7 coming in should have an agreement with the state in order
8 to operate.

9 CHAIR THOMPSON: Okay. Kit.

10 COMMISSIONER GORTON: Good morning. Thanks for
11 coming. So you all have talked a lot about key success
12 factors in your programs, and that's very helpful. But
13 this time of year, we're all reminded that nobody bats a
14 thousand, and I sort of wonder whether you have
15 observations about decisions that you might have made
16 differently. You have the opportunity. You are leading
17 states. People are paying attention to you. I just want
18 to give you the opportunity to say to the Commission and to
19 the broader audience, are there things that you would
20 recommend people not do, again, mistakes that you made,
21 things that you learned from, things that didn't play out
22 the way that you intended them to?

1 MR. BETLACH: You want to go first?

2 MS. KIMSEY: I'll start.

3 MR. BETLACH: You have recent experience moving
4 back and forth.

5 MS. KIMSEY: That's right, and so I think the one
6 I would touch on first and foremost is the care
7 coordination, care management, and that we didn't start
8 with ratios, and stronger expectations for our requirements
9 related to what that looks like. And so there was a lot of
10 confusion when we first started, and I'll give an example
11 like with the nursing home industry. They just said, hey,
12 we were already paid to take total care of this person,
13 what good is the plan going to do other than just another
14 layer on top of us?

15 And so we had to spend quite a bit of time with
16 them to outline what that role actually looked like and how
17 the benefit would be realized for them and for the member.
18 So we always start with the member, and then we work around
19 with the other systems. And so for us, that was a
20 significant learning curve, and to the point where that's
21 why we have strong ratios in place, and I would offer that
22 as one of the biggest ones that we had.

1 MR. BETLACH: The redo we want is clearly around
2 the competitive Medicaid bid side and the fact that we now
3 have new plans in certain regions and that those
4 individuals that are being served are now unaligned. And
5 so that member then has to figure out, again, am I going
6 back to Medicare fee-for-service? Am I going to do another
7 MA plan? Who is this new plan that's serving me? And so,
8 you know, I just think it's an unfortunate reality that I
9 thought we had a tool for and we needed to do a better job
10 as an organization recognizing the front-end planning, and
11 even though we spent two years leading up to this
12 procurement, that is clearly one of the areas that I would
13 like a redo, and I think it's something state Medicaid
14 agencies need to be cognizant of in this journey. As you
15 go through those competitive Medicaid procurements, what is
16 it doing to your alignment? And what are the strategies in
17 terms of really using the authority that now exists to try
18 and make that less impactful on the member?

19 MS. KIMSEY: I have one more tiny one. So what
20 defines a clean claim? And that's been a very interesting
21 concept. We said clean claims within periods of time --
22 because, believe it or not, even though the federal

1 standard is 30 days, we paid within 14 under the fee-for-
2 service model. And also the Medicare side, they're fairly
3 used to a regular process. And so we had providers come
4 and complain to us plans weren't paying timely, plans were
5 saying they were, so clean claim has to mean a complete
6 full payment claim, not partial or incomplete payment. And
7 so we had to define that, but we found ourselves being
8 repeatedly pulled into the Medicare side as well to ensure
9 those claims were paid timely for them, even though we
10 weren't involved, you know, don't oversee that program, we
11 helped with those claims resolutions problems. So that was
12 an unexpected twist for us, and we've straightened that out
13 in our contract language.

14 CHAIR THOMPSON: Great. Tom, Karen, we're almost
15 at time, but we can run late if you can so that we --

16 MR. BETLACH: I can.

17 MS. KIMSEY: I have a --

18 MR. BETLACH: A meeting with the governor, right?

19 MS. KIMSEY: In a few hours.

20 CHAIR THOMPSON: All right. We won't --

21 MS. KIMSEY: But I can give a few more, a couple
22 more.

1 CHAIR THOMPSON: Okay -- impose too much on you,
2 but I'd like to get the Commissioners, all who want to ask
3 questions, to have their chance at you.

4 MS. KIMSEY: Sure.

5 CHAIR THOMPSON: Sheldon.

6 COMMISSIONER RETCHIN: Well, thanks to you both
7 for being here, and I have a long association with Karen
8 back at DMAS, so a special shout-out, and really a shout-
9 out to Melanie for now -- I think she's been a terrific
10 addition to the Commission, and this is such an important
11 area, so I'm really delighted we're spending more time on
12 it.

13 I have, I guess, a question, back to both of you,
14 but maybe as much Tom as well as Karen, and I'll extend the
15 metaphor that I'm looking at opt-out rates and some of the
16 issues that are related to that. And in that case, I'm
17 reminded that actually batting .300 gets you in the Hall of
18 Fame. These opt-out rates have been pretty high in some
19 areas of the country and then not others, and I'm
20 interested in whether -- it doesn't really seem to -- they
21 don't really seem to follow the Medicare Advantage
22 penetration rates. Maybe there's some association. But

1 I'm intrigued, first of all, why. I never could figure out
2 why MA has had such a difficult time in Virginia and have
3 low penetration rates and whether, Karen, you have found
4 that that had some issue to do with the opt-out rates and
5 some of the alignment initiative; and then, Tom, how you
6 were able to speculate on the 11 percent opt-out rates in
7 Arizona.

8 MS. KIMSEY: I did want to shout out to
9 Commissioner Retchin because it was his plan that took the
10 leap with us under the FAD.

11 COMMISSIONER RETCHIN: Lost 21 million.

12 [Laughter.]

13 MS. KIMSEY: And we're so grateful.

14 COMMISSIONER GORDON: You invested. You invested
15 41 million.

16 MS. KIMSEY: But, you know, if you'll recall, we
17 have a pretty rural area out in southwest Virginia, and
18 managed care is considered a dirty phrase. And so people
19 tend to feel comfortable with the Medicare environment
20 under fee-for-service and would say, "I'm just going to
21 stay there, thank you," and would not even engage it. So
22 that's one of the -- that's why I was talking about an

1 educational process that we need to do out there to help
2 people better understand, and a lot of people don't even
3 understand they're in managed care Medicaid. They think
4 they're with Premier or they're with Anthem. They don't
5 even understand what that is. So for us, it's an
6 educational component. And, also, on the FAD side, it
7 absolutely had to do with providers, hospital systems,
8 physician groups, and long-term care providers in
9 particular, saying if you participate in this, you have to
10 find somewhere else to go, and people would become very
11 distressed, and our federal partners actually had to reach
12 out and send a letter saying, "You can't batch disenroll
13 people. That goes against your licensing requirements, and
14 you'll be tagged on that."

15 Related to that, we had a huge struggle with
16 that. It had not to do with people choosing to leave, more
17 than the influence of the providers serving them
18 influencing them to leave.

19 MR. BETLACH: Well, as a Milwaukee Brewer fan,
20 I'm a little distressed by all the baseball metaphors, but
21 I'll move on beyond that and get into the conversation in
22 terms of this, and I'm sure Commissioner Douglas has

1 thoughts on the disenrollment experiences as well given
2 California.

3 But, you know, I think it's all so much dependent
4 upon the local environment. MA has a very strong
5 penetration rate in the state of Arizona. We've had
6 Medicaid managed care for three-plus decades, very well
7 accepted as the delivery system in our state. In terms of
8 the 90-percent-plus retention on the default enrollment, I
9 mean, those individuals already have experience with that
10 plan on the Medicaid side, and so they know who Mercy Care
11 Plan is, they know who United Health Plan is. And so I
12 think so much of that helps in terms of achieving a success
13 rate like that, and I know our numbers are also very
14 reflective of what's going on in Tennessee where they have
15 a 90-plus-percent retention rate through that process.
16 And, again, I think it's reflective of the relationship
17 they have built with that organization.

18 And so, you know, I knew that we were having
19 tremendous success on D-SNP alignment when we sat down with
20 our nursing facility partners who, again, you know, they
21 have worked a long time with managed care in the state of
22 Arizona, but they came to us and they said, you know, we

1 need rate increases because we're seeing a lot fewer
2 hospitalizations for our individuals that are in nursing
3 facilities because of the work being done by your managed
4 care organizations, to which what does that say about the
5 incentives that have been created by the federal government
6 where you need nursing facilities that have to have people
7 to go into an inpatient setting so they're viable? I mean,
8 how perverse is that in terms of really creating a
9 structure?

10 And so I think so much of what plays out on these
11 different types of enrollment mechanisms are really
12 dependent upon sort of the local culture that's in place.

13 CHAIR THOMPSON: Brian.

14 COMMISSIONER BURWELL: I'd like to echo thank you
15 both for coming. Particularly nice to see Karen, one of my
16 best former colleagues I've ever worked with. And, Karen,
17 I will give you the first question. I applaud your focus
18 on care coordinators, care management. I think it's an
19 extremely important part of integration. The person who's
20 actually in the home knows the member the best, and a
21 highly trained, highly motivated care coordinator I think
22 is key to the success of these kinds of models.

1 I'm interested in how you tried to integrate that
2 across both your D-SNPs and your MLTSS plans. I heard many
3 stories of people having two different care coordinators
4 and getting confused who pays for these people. Are your
5 Medicaid plans picking up the entire cost of this? Are
6 your D-SNPs picking up some of the cost? How are you
7 managing this?

8 MS. KIMSEY: We have the same care coordination
9 requirements, aside from the ratios, embedded in our MIPPA
10 contract as well, as with our Medicaid contract. So we
11 aligned them for that purpose. But as for the cost for the
12 care coordinators, I mean, we have commitments and work
13 with our plan partners that an individual will have the
14 same care coordinator, not two different ones, for their
15 Medicare and Medicaid benefits if they're aligned. And so
16 that's the optimal piece that we shoot for.

17 As for the payment for it, I mean, at this point
18 we are absorbing the cost -- that's how I understand it --
19 on our admin loads related to their costs. So I'm not
20 sure. We haven't worked to -- just because it's just
21 within our second year working with the MIPPA contracts to
22 this level, started to look at maybe shared costs related

1 to that on the care coordinator side, for the admin costs
2 at least.

3 COMMISSIONER BURWELL: I guess we each get two
4 questions. So my second question is to Tom. At the end of
5 your presentation, you talked about the longer-term
6 solution and having one program for duals and then
7 commenting that it's probably not a good idea to give the
8 driver of the bus to the federal government given their
9 lack of expertise around MLTSS or LTSS, which I agree with.
10 But you didn't say about the other -- you know, the -- what
11 you didn't say was then, well, what are the barriers to
12 giving it to the states?

13 MR. BETLACH: I think some of the barriers just
14 exist within the concerns around states and how they
15 manage. I think what you're hearing from are a couple of
16 states that are very mature. There are other states around
17 the table -- and Melanie obviously, through her efforts at
18 the federal level -- that have spent a lot of time on this.
19 But we've also talked about those states that have not had
20 the bandwidth to be able to really spend a lot of time on
21 dual-eligible members. So I would think that some of the
22 concerns around any type of that strategy would be what do

1 you do with those states that historically have not pursued
2 a lot of different strategies in terms of creating
3 alignment and pursuing other things like that.

4 COMMISSIONER BURWELL: Do you also see a
5 potential collaborative solution? Because this seems to be
6 the big --

7 MR. BETLACH: Right. I mean, at the end of the
8 day there has to be collaboration, just as there is on the
9 Medicaid side, right? States don't stand alone on
10 Medicaid. It's a collaborative effort. I'm just saying
11 that at the end -- when you look at the structure, we would
12 never create a system like that now. So why should that be
13 the reason that we continue it on in perpetuity.

14 MS. KIMSEY: Absolutely.

15 COMMISSIONER BURWELL: Thank you.

16 CHAIR THOMPSON: Okay. Toby, you get to take us
17 out.

18 COMMISSIONER DOUGLAS: So there's one I was going
19 to ask on the provider side, but I'll leave that alone.
20 Thank you both for coming. The final one will be around
21 behavioral health. We haven't really talked much --

22 MR. BETLACH: Right.

1 COMMISSIONER DOUGLAS: -- about behavioral, and
2 many states there's carveout or separate systems, and yet a
3 huge part of integration. So if you could talk about what
4 you've been doing in that area.

5 MS. KIMSEY: Well, I'm excited about that one
6 because I've been living and breathing that very heavily
7 for the last eight years. And so we've fully integrated
8 that as of January of this year into our managed care
9 systems, and so we firmly believed we saw a huge disconnect
10 with carving it out, that people would receive services and
11 supports, and even though we reported it into the plans, it
12 would come later. They wouldn't know necessarily. There
13 was a lack of connection with our primaries in terms of the
14 care that they were receiving. And we actually did a study
15 with Colorado, the Farley Center, that looked at touch
16 points. Where do people actually receive behavioral health
17 services? And the reality is that 42 percent of all of our
18 members received it through their primaries. It's not
19 necessarily through -- their primary care physicians, not
20 through the behavioral health systems. And for children
21 it's in schools.

22 And so we actually are moving and working in

1 tandem with our health plan partners because we have a very
2 robust mental health system. We spend almost \$1 billion a
3 year on behavioral health. But it's primarily crisis-
4 driven. It's not trauma-informed, preventive-focused, and
5 so our evidence-based -- like our ARTS program is, our
6 addiction and treatment. And we are working over the next
7 year to create that north star with our health plan
8 partners and our systems in place to design that continuum
9 of care to better reflect members' needs and where they are
10 and meet them where they are. And that will include
11 integrated behavioral health and primary care platforms as
12 well under value-based payment strategies.

13 So we're really excited about that, and --
14 because at one point we were trying to make fixes here and
15 there, and it was like playing whack-a-mole. You were so
16 right. I use that all the time. And any time we'd make a
17 fix here, it would balloon out somewhere else, and it
18 wasn't always for the positive benefit of a member or even
19 the most efficient for high quality or efficient costs to
20 the Commonwealth. And so that's where we're heading.
21 We're very excited to have our plan partners --

22 COMMISSIONER DOUGLAS: [inaudible] contracts,

1 too?

2 MS. KIMSEY: Yes. Yes, we will be.

3 MR. BETLACH: So that's a very important
4 question, and we could spend a whole other presentation --

5 MS. KIMSEY: Yes.

6 MR. BETLACH: -- talking about integration and
7 integration efforts particularly in Arizona. So this has
8 been a multi-year journey for us. We have been focused on
9 actually three layers of integration. The first is the
10 policy where we used to have a separate state agency that
11 was involved in behavioral health services. We merged that
12 into our organization, and so I'm a Medicaid director that
13 has control of all the block grants. So all the substance
14 use disorder funding now flows through us, flows through
15 the managed care organizations. Along with that came
16 resources for housing for individuals with serious mental
17 illness. So the Medicaid agency in the state of Arizona is
18 now the third largest housing authority in the state of
19 Arizona. We have employment support resources. And so we
20 have all this expertise now that sits within a singular
21 organization, really focuses on the contract and the
22 policies around supporting integration and the delivery

1 system.

2 At the payer level, we've braided all the funding
3 streams, so the plans are responsible for the full array of
4 services, so we know with individuals with serious mental
5 illness, 40 percent of that population are dual-eligible
6 members. So we have products in Arizona who focus on
7 individuals with serious mental illness, a full array of
8 services, including over 5,000 individuals that we're
9 housing with state-only dollars. With that population,
10 we're building housing support, employment support services
11 around those individuals. We have a third-party evaluation
12 that's coming out on that model. It's not out public yet,
13 but some of the results are great. So COPD, asthma
14 admissions, gone from 130 per 1,000 down to about 95 per
15 1,000, as just an example of some of the outcomes
16 associated with that.

17 So behavioral health is critical. It's one of
18 those important services that exists within the Medicaid
19 that's not robust in Medicare, and when you look at the
20 impact on some specific services like peer support services
21 and other things like that that Medicaid's able to bring to
22 the table, incredibly important. And so we've integrated

1 at the policy level. We've aligned all the funding streams
2 at the payer level in order to support providers to be more
3 integrated in terms of serving our population, so that it's
4 not up to the member to have to navigate all these
5 different systems of care, but the system is there to serve
6 the member.

7 CHAIR THOMPSON: Great. Tom, when that third-
8 party evaluation is publicly available, I hope you'll shoot
9 a copy over to us --

10 MR. BETLACH: We will, yes.

11 CHAIR THOMPSON: -- so we can be sure to take a
12 close look at that. That's very interesting.

13 All right. We've taken beyond what we allotted
14 for your time, but that's no surprise. This is a common
15 theme when we get some state officials in here talking
16 about their experiences. And you two are among the leaders
17 around this subject, and we really appreciate your coming
18 here to share your insights and your expertise. You've
19 given us a lot to talk about, and I'm sure we'll continue
20 to rely on you for additional thoughts as we go along our
21 process. So thank you very much.

22 MR. BETLACH: Thank you for having us.

1 MS. KIMSEY: Thank you.

2 [Applause.]

3 CHAIR THOMPSON: So we will take a break and be
4 back at 10:30, and then we will pick up a Commissioner
5 conversation to follow up on what we just heard.

6 * [Recess.]

7 **### FURTHER DISCUSSION: STATE EXPERIENCES INTEGRATING**
8 **CARE FOR DUALY ELIGIBLE BENEFICIARIES**

9 CHAIR THOMPSON: Okay. Welcome back, everyone.
10 We'll pick up, then, with this subject in a
11 Commissioner conversation.

12 First of all, again, what a rich and informative
13 conversation we just had, and I think it really builds well
14 on some of the initial discussions that we had in our
15 September meeting, hitting some of the same things, but I
16 think giving us a deeper understanding about some of them
17 and then identifying potentially some new issues for us to
18 think about.

19 So, Kirstin and Kristal, we talked about -- can
20 you just remind us so that Commissioners can have in their
21 minds when the last time we did a chapter on duals was, so
22 that we can think about what the shape perhaps of some

1 upcoming chapter next year might look like?

2 * MS. BLOM: Sure. So Kristal and I were just
3 doing a little research actually because the last time we
4 did a chapter was before both of us were working here.

5 [Laughter.]

6 MS. BLOM: But it was in March 2013, and it was
7 titled "Roles of Medicare and Medicaid for a Diverse Dually
8 Eligible Population." It talked about the different roles
9 that the two programs play. It looked at like spending
10 between the two programs, things like that.

11 Since then, obviously we do have other
12 publications. We have the data book, which we do every
13 year. We have issue briefs on the duals demos.

14 Oh, also, in Kristal's MLTSS chapter in June of
15 this past year, there was a section on integrated care
16 because we thought that you guys would be interested in
17 moving forward on that. So that's where we are.

18 EXECUTIVE DIRECTOR SCHWARTZ: Also, I believe it
19 was in 2015, we did a whole series of empirical work and
20 then had a policy discussion around Medicaid payment for
21 Medicare cost sharing. It started off "What is the effect
22 of Medicaid payment policies on access?" and it sort of

1 broadened out from there as well. We have done a few
2 things as a Commission since 2013.

3 CHAIR THOMPSON: All right. I'll start off the
4 conversation by suggesting maybe a path.

5 It seems like we have enough data and state
6 experience to draw upon to try to develop something around
7 supports and activities states need to engage in, in order
8 to promote alignment. In that context, there could be
9 identification of these strategies that have made some
10 states successful, things that they've learned as a result
11 of implementing those, ways in which we could contemplate
12 changes to federal authority or the need for additional
13 resources.

14 As always, in this arena, we sometimes confront
15 this question about whether we would be making
16 recommendations about Medicare policy, which is outside of
17 our brief, but I think there are some places where we are
18 going to rub up against that a little bit. And we'll have
19 to navigate that, but some of the issues around the look-
20 alike and other things that affect the market in which the
21 state is operating when they're trying to achieve a set of
22 objectives and then maybe there's some competitive force at

1 play that present challenges and so forth.

2 But it seems like that could potentially be a
3 rubric around a number of these issues that we've talked
4 about in terms of, for example, what do we know about
5 savings? What do we think about the attribution of those
6 savings? What kinds of things can the federal government
7 do to be and continue to be a good partner to the states in
8 helping promote some of this? Are there some other
9 Medicaid-specific policies at the federal level that are
10 barriers or impediments or helps where we need to be
11 focused?

12 Yes, Darin.

13 COMMISSIONER GORDON: I like what you're
14 suggesting around addressing some of those potential
15 barriers or those new kinds of created entities or
16 approaches that are starting to undermine where there's
17 been some progress and shining a light on that. I don't
18 think there is any reason why you wouldn't require like a
19 MIPPA agreement for I-SNPs or in dealing with these -- what
20 did you call them? -- the look-alikes and trying to address
21 those as well.

22 To the extent that you're basically a D-SNP and

1 you don't have a MIPPA agreement and you're not exchanging
2 information with the Medicaid agency, you're not looking at
3 their expectations on coordinating with the other part of
4 that equation, then it really begs the question of how you
5 could be a D-SNP In that scenario.

6 Granted, I think Melanie has made the observation
7 that, in some cases, they're doing that because they're not
8 being allowed. They're not getting a MIPPA agreement, so
9 that's something that's being navigated.

10 But I do think pointing to those new kind of
11 creations as being a hindrance to a particular alignment
12 pathway, it's worth saying something about.

13 CHAIR THOMPSON: Bill.

14 COMMISSIONER SCANLON: I guess there's an area
15 where I think we're not ready to learn enough in the short
16 term, but it was mentioned the federal government has very
17 limited experience with LTSS, and the states have a whole
18 lot more.

19 But when you look at it -- and I'm extrapolating
20 from the dollars -- there's incredible variation in that
21 experience, and I feel like that we need to know what that
22 variation means for beneficiaries.

1 LTSS to me has always been this problematic area
2 of what exactly is the role of formal support and then
3 particularly what is the role of subsidies of formal
4 support. Knowing that, I think it's critical to moving
5 forward in terms of justifying the investments or
6 expansions of the investments, and we haven't done a good
7 job forever, I guess is kind of the way I'd put it. I
8 think we really need to understand what is the impact for
9 individuals and their caregivers from different levels of
10 services and different levels of investments. That to me
11 is as important or more important than any kind of savings
12 that come from different arrangements.

13 CHAIR THOMPSON: So reactions to that or comments
14 on other --

15 COMMISSIONER GORDON: I have a question. Are you
16 saying on the LTSS side in trying to understand -- I was
17 trying to see if that was more like a sub-point to kind of
18 the dual alignment, or are you saying that the issues
19 around what is going on in LTSS is paramount, coming to the
20 conclusion that alignment is good? I'm not following you.

21 COMMISSIONER SCANLON: Well, I mean, it's partly
22 an issue of taking advantage of the opportunity of

1 alignment presents, and if we're going to be studying sort
2 of what is happening as the result of alignment in terms of
3 the services that are being provided to these individuals -
4 - this is a question we should have been asking sort of
5 even when we were paying fee-for-service, which we didn't,
6 but now as we are moving forward and we want to make a
7 greater commitment to an aligned approach and we talk about
8 evaluation is essential, I'm saying that I think we need to
9 put on the table that a part of that evaluation needs to be
10 what are the consequences in terms of the differences in
11 service delivery on the LTSS side.

12 And then that will translate to when you're
13 engaged in a contract, engaged in contracting, what are the
14 standards you put into a contract for performance. I think
15 we have to have that eventually.

16 CHAIR THOMPSON: Melanie.

17 COMMISSIONER BELLA: I'm not sure I 100 percent
18 understand exactly.

19 I would say that for the financial alignment
20 evaluations, they all have prescriptive requirements around
21 care models for LTSS and care plans and this and that, and
22 RTI is evaluating each of those pieces. I don't know if

1 that's the evaluation you're talking about or if you're
2 saying -- I mean, there is an evaluation to be done about
3 the correlation between a state's LTSS program and Medicare
4 post-acute spending, for example. Hilltop did this years
5 ago to show the relationship between a well-funded, a well-
6 resourced Medicaid system, and what that does for people
7 and sort of the totality of the cost. And I think those
8 are important relationships to understand.

9 So I'm not 100 percent. I'd just mention the
10 evaluations, and they're slow, and they're -- no offense to
11 any of the academicians -- academic. And so the states
12 have been making changes, so they may or may not tell us
13 what we want.

14 But the point I wanted to make is there's a
15 tremendous amount we could do to help states, but there are
16 also a lot of organizations out there, like the integrated
17 care resource centers, CHCS, and others. I mean, they're
18 responsible for putting together like these technical
19 assistance tools on how to do a MIPPA contract and how to
20 think about this. I feel like there's an untapped area for
21 people that are sort of flagging regulatory or statutory
22 misalignments in the Medicaid and Medicare program that are

1 impeding alignment. That as we're getting more experience
2 in alignment, these become bigger issues than they were in
3 the beginning.

4 So I would kind of throw a vote in for focusing
5 on those things that are getting in the way because they
6 weren't the same things that were getting in the way five
7 years ago. There's new things getting in the way.

8 So while I'd love to see us build an amazing
9 Medicare team in every state, I don't think that's as
10 relevant for us as it is to continue flagging these things.
11 And then it does require, though, that these are things
12 where we're going to bump right up into Medicare, so
13 understanding how we can continue to work closely with
14 MedPAC.

15 CHAIR THOMPSON: In the context of my suggesting
16 something like here are the enablers and here are the
17 barriers, you're more interested in the barriers because
18 you feel like there's more attention being paid to --

19 COMMISSIONER BELLA: I mean, I think if it's like
20 -- so enablers are like default enrollment and cross-
21 walking and this and that. There's a bunch of people
22 telling states how to do that. There's not as many people

1 saying, "We still have an issue because Medicare regulation
2 doesn't allow this," and for a state to align, this
3 happens, or "Medicare regulation trumps." So there's still
4 --

5 CHAIR THOMPSON: Yeah.

6 COMMISSIONER BELLA: There's still an area of
7 work to be done there.

8 Yeah, there's a ton of work to tell the states on
9 enablers. I'm just suggesting some other folks might
10 already be doing that.

11 CHAIR THOMPSON: Yeah. Sure.

12 COMMISSIONER BELLA: But I'm not sure that
13 they're doing the other piece.

14 CHAIR THOMPSON: Right, right. Okay.

15 Chuck. And Alan wants to get in, Brian wanted to
16 get in. Others right now? Okay.

17 COMMISSIONER MILLIGAN: I do think it would be
18 helpful.

19 I was talking to Tom after we broke for a second.
20 I haven't read the CHCS materials on MIPPA, and I guess
21 there's sort of a compendium or a side-by-side comparison.

22 I think learning a little bit more about best

1 practices in MIPPA would help us, especially around the
2 look-alike issue, kind of what are the factors by which we
3 would determine that the states advancing good policy
4 around D-SNP in a way that might inform us around any
5 federal commission kind of recommendation around look-
6 alike if we want to weigh in on this.

7 I do think having a little bit more kind of
8 insight into the spectrum, and to me, part of it is -- and
9 we heard some of this from the panel -- what are the must-
10 haves in a MIPPA agreement for it to really work? Care
11 coordination is a piece. Encounter data is a piece. Some
12 of that, I think we need to start thinking about what does
13 alignment look like in terms of kind of the minimal viable
14 product, if you will, piece of it.

15 But I want to talk about an enabler that we
16 haven't really touched on yet, which is the enhanced
17 benefits in a D-SNP. I'll sort of talk about United, but
18 we're, by no means, unique. This isn't a sales thing
19 because we're not unique in terms of how this is done.

20 But in our D-SNP, we offer dental benefits,
21 including twice-a-year cleanings and dentures and things.
22 We offer eye exams and eyeglasses. We offer over-the-

1 counter medications. We offer meals after somebody is
2 discharged from a hospital for a period of time so they can
3 have stable food. There's expansions now into more social
4 determinants of health that are part of D-SNP. We offer
5 transportation, a whole other kind of array, the 24/7 nurse
6 line. We offer a personal emergency response system, like
7 "I have fallen. I can't get up" stuff.

8 So I think part to me -- and the reason I'm
9 getting into that is, What determines the opt-out? And
10 some of what mitigates opt-out is people getting benefits
11 inside the D-SNP that they are not going to get in original
12 Medicare, and so there's the member side of it, which
13 creates stickiness. There's a provider side, which creates
14 stickiness too, around quality bonuses for Stars and HEDIS.

15 To me, one of the things that I would like to
16 learn more about in terms of just the difference between 16
17 percent aligned in one place and 48 percent aligned in
18 another place is what are the factors that influence that.

19 I don't think it can just simply be explained by
20 provider resistance to managed care. I think there are
21 other elements of that, that enable alignment, enable
22 stickiness with a managed Medicare program, and to what

1 extent -- when I get into, kind of go into that whole list
2 of enhanced benefits and so on, to what extent is a state
3 influencing in the MIPPA process what they want their D-
4 SNPs to offer that can help to take pressure off of states
5 about dental benefits or vision benefits or HCBS benefits
6 for people who don't necessarily qualify for Medicaid LTSS.

7 The other one, while I'm kind of on a roll about
8 this, the state fiscal impact for D-SNP -- and, again,
9 we're by no means unique, but we buy down the state co-
10 insurance and deductible. Whereas in original Medicare,
11 often the state has to pick up cross-over claims, a lot of
12 what we do with our D-SNP is we buy that down and pay that
13 state cross-over claim obligation. When somebody is in a
14 Medicare Advantage program, the state is not going to see
15 cross-over claims at all, whereas on the original Medicare
16 side, they would.

17 That fiscal benefit to states -- I think in New
18 Mexico, we're producing \$6 million a year benefit to the
19 state by just doing that.

20 So those pieces, I think, are typically not
21 brought into these discussions as enablers, and I think the
22 more we can illuminate that, it would help us then

1 determine where we want to weigh in on federal policy.

2 CHAIR THOMPSON: Alan? Alan passes.

3 Brian.

4 COMMISSIONER BURWELL: So I think one of the
5 reasons why Arizona is at 46 and Virginia is at 16 is just
6 time in the program. Arizona has been at it a lot more.

7 Karen also told me afterwards that when Virginia
8 transitioned out of the demonstration back into just MLTSS
9 and D-SNPs, CMS arbitrarily limited the number of Medicare
10 beneficiaries that could be in aligned plans to 2,000,
11 something like that.

12 COMMISSIONER BELLA: I got to correct that. I
13 wasn't there, but it wasn't an arbitrary determination.

14 Unfortunately, it was found to be more cost
15 effective to put those folks back into fee-for-service. So
16 the majority of folks, all but 2,000, because of the
17 benchmarks, the Medicare benchmarks, and the way the costs
18 are calculated and the rural counties, it was a cost-
19 effective issue, and so they did not cross-walk them into
20 the corresponding D-SNP.

21 There's nothing arbitrary about it,
22 unfortunately. It was actually calculated, which is almost

1 worse, because it's saying that we still think it's more
2 expensive to put people into integrated products, but that
3 was why, just for the record.

4 COMMISSIONER BURWELL: Okay. I'm just being the
5 messenger.

6 I guess I feel like we should have a more
7 extended discussion about what our strategy is here. I
8 guess I'm in Melanie's camp that recommendations around
9 continued investments and infrastructure may not be
10 necessary and are relatively minor, and that our task is
11 more on the real policy changes.

12 But there's so much that we could address. I'm
13 not really clear how we would want to sort that out.

14 CHAIR THOMPSON: Well, that's the challenge,
15 right?

16 COMMISSIONER BURWELL: That's the challenge.

17 I also think usually we develop recommendations
18 in association with some kind of -- well, I'll say another
19 thing. I think we would be more well positioned if we had
20 more evidence behind us when we move forward and promote
21 integrated models. So if these evaluations come out and
22 show positive outcomes, that would be a very good time.

1 Third, we have our own internal -- we have work
2 that we're doing. We usually tack our recommendations onto
3 some work that we've done. So I would like to spend more
4 time talking among ourselves about which direction we want
5 to go in to have a strategy around this.

6 CHAIR THOMPSON: Well, let's at least maybe try
7 to formulate a plan now. I don't know that we're -- I
8 mean, we hopefully get smarter every day, but I think the
9 purpose of our conversations last time and this time were
10 to try to get at least a formulated approach to what we're
11 maybe trying to focus on.

12 It sounds like -- let me just test the
13 proposition. It sounds like there's one constellation of
14 things, which is about taking stock of value and savings.
15 Where do the benefits come from? What are the things that
16 influence where benefits flow to members, to plans, to
17 states, to the feds, both with respect to delivering
18 coverage and benefits and with respect to savings? What is
19 the state of the research about that?

20 I mean, we're not going to, obviously, have
21 perfect answers on all of that, but I think there has been
22 a fair amount of ground covered.

1 To the extent that both the federal government is
2 trying to promote alignment and states are trying to take
3 advantage of that alignment, based on those perceived
4 values and benefits, are there key enablers and key
5 barriers?

6 I think that it sounds like perhaps understanding
7 the state of the barriers today, sort of picking up on
8 Melanie's point, is where maybe people would like to spend
9 more of the time, particularly if it's been a while, which
10 it has, since we've tackled some of these issues and taken
11 a look at them and ground has changed underneath of us in
12 some respects and we've gotten more state experience, so to
13 the extent that there are these kinds of issues that arise
14 and that we may want to respond to, which would set us up
15 to potentially make recommendations, maybe not, but
16 certainly give us kind of an outline for a chapter.

17 Anne.

18 EXECUTIVE DIRECTOR SCHWARTZ: Yeah I also want to
19 remind you that we have three projects underway that will
20 give us information that seems quite relevant to this.
21 One, an inventory of what we know about integrated care
22 models, the second on what states are doing in terms of

1 care coordination in their managed care contracts, and a
2 third on factors affecting enrollment and disenrollment,
3 we'll start having some of that for you soon, but probably
4 not until sometime in the winter.

5 And so, I just want to remind you that that
6 information is coming and it's new information that bears
7 on these issues.

8 CHAIR THOMPSON: Thank you, Anne. I think that
9 fits very much well within what we're talking about.

10 So any reactions?

11 COMMISSIONER GORDON: Anne, on the one I was
12 talking about, care coordination, that's included in
13 contracts, is that broad enough to encompass even like
14 Anthem or MIPPA contracts?

15 MS. VARDAMAN: Hi. So yes, we have a contract
16 underway right now with HMA and it's two phases. One is
17 looking at the contract requirements between states and
18 plans and what states are requiring of plans in terms of
19 their care coordination standards. The second piece is
20 talking to a variety of stakeholders -- states, plan
21 providers, consumer advocates -- to understand kind of how
22 things work on the ground, how states are learning, and,

1 you know, adjustments that they made over time. And for
2 the contract review we are including looking at the states
3 that are doing MLTSS along with D-SNPs and what their MIPPA
4 requirements and plans look like.

5 CHAIR THOMPSON: Any questions, Kirsten or
6 Kristal, about what we've said here in terms of thinking
7 about some of these different buckets, which will obviously
8 require you to think a little bit about what belongs where
9 and what do we have now and how do these pieces come
10 together in support of that and where might we have some
11 gaps where we need to fill in?

12 MS. BLOM: I think we can talk amongst ourselves,
13 based on what you guys have said, and come up with
14 something.

15 CHAIR THOMPSON: Okay. Good.

16 COMMISSIONER BURWELL: So I just want to throw
17 out, so you're saying we'll get the results -- we'll get
18 these reports in for the February meeting? I'm just trying
19 to create a scenario here, which would then -- and then we
20 would have a couple of meetings to think about
21 recommendations with maybe something more solidified at our
22 last meeting in the spring, and something that we could

1 include in the June report? I'm just throwing stuff out.

2 EXECUTIVE DIRECTOR SCHWARTZ: So one of those we
3 were going to have for January, or was it March?

4 MS. BLOM: Well, we might have the enrollment one
5 for December.

6 EXECUTIVE DIRECTOR SCHWARTZ: Okay, for December.

7 MS. BLOM: And then the care coordination is a
8 little bit later.

9 EXECUTIVE DIRECTOR SCHWARTZ: Yeah. I guess,
10 Brian, the question is that, in part, whether you want to
11 make recommendations that will depend upon what we evaluate
12 from what we learn, and then to sort of think about what
13 does that show in terms of an action step for it. It's a
14 little bit hard for me to imagine that you could -- I don't
15 know. Maybe on the December one something will bubble up,
16 but if it's going to be a little bit later it's hard for me
17 to imagine how you're going to have recommendations in this
18 report cycle, although you might have a very robust
19 discussion of some of the issues. But, you know, I could
20 be surprised. Maybe something is going to pop out that's
21 really glaring.

22 CHAIR THOMPSON: Or it may just be that, you

1 know, it's sort of a taking stock chapter with a lot of
2 rich information that kind of puts us in a better position
3 for next year. Again, I think we have to kind of see how
4 it all comes together from a timing perspective.

5 Martha, you wanted to jump in.

6 COMMISSIONER CARTER: I'm trying to formulate my
7 question, and we had a little conversation at the break, to
8 the extent that the practices that -- the entities that
9 managed care plans would contract with -- to the extent
10 that they can help the success or not of these projects.
11 Does it make sense to look at how -- what's the experience
12 of that level of the health care system in these projects?
13 And maybe somebody -- maybe you can help me elaborate that
14 question, Chuck, but it does seem -- I don't know. I don't
15 know that experience. I don't have any lived experience
16 with that. But it seems like there are things that the
17 plans can do to encourage support from the practices, from
18 the hospitals, from the nursing homes, whatever it is that
19 you're trying to contract with.

20 CHAIR THOMPSON: It seems like in that
21 constellation of questions that we have about savings and
22 benefits, the practice level needs to be part of that

1 frame.

2 COMMISSIONER MILLIGAN: But I think Martha's
3 comment is a little broader. To the extent that patients
4 trust their providers, the provider experience with MLTSS
5 or D-SNP influences whether there is alignment, whether the
6 member opts out. So I think it's kind of what are the
7 factors by which the provider is an element of the success
8 of a program that will help retain the membership inside of
9 an aligned model.

10 CHAIR THOMPSON: Well put. Thank you.

11 COMMISSIONER CARTER: And to the extent that the
12 care coordination is also helping or not at the practice
13 level, at the health care provider level, because those are
14 activities certainly that are happening at the community
15 health centers' care management. But how are those
16 activities then affected by what's happening in the D-SNP?

17 CHAIR THOMPSON: Any final comments from the
18 Commissioners before we move on?

19 [No response.]

20 CHAIR THOMPSON: So, you know, we've given you a
21 lot of things. I think what we're going to ask you to do
22 then is kind of put that up against the current research

1 agenda and sort of see what you think we can pull together,
2 what may need some deeper dives. I think there will be a
3 couple of bites at this apple for this Commissioner group
4 to kind of ask some questions and dive into some details
5 where we think there might be some benefit to doing so. So
6 we will look forward to those additional conversations.

7 CHAIR THOMPSON: Okay. Let's move on to the next
8 subject and the last session for this meeting. Martha's
9 going to end our October meeting with a bang on
10 eligibility, enrollment, and renewal processes.

11 **### ELIGIBILITY, ENROLLMENT, AND RENEWAL PROCESSES:**

12 **FINDINGS FROM STATE CASE STUDIES**

13 * MS. HEBERLEIN: So no pressure there whatsoever.

14 As you all know, the Patient Protection and
15 Affordable Care Act or ACA made significant changes to
16 Medicaid enrollment and renewal processes, with the goal of
17 making the program more efficient, reducing complexity and
18 effort on behalf of enrollees and program administrators,
19 and integrating Medicaid with the health insurance
20 exchanges.

21 So in September of 2017, the Commission discussed
22 these changes and expressed interest in examining the

1 status of state systems and processes used to support
2 Medicaid program eligibility, enrollment, and renewal, and
3 so today I will present the findings from that work.

4 So I will begin by providing some brief
5 background on the changes made under the ACA before I talk
6 about the case studies and the key themes that we found,
7 and then I'll conclude with some of the things that states
8 are looking forward to in the next few years before turning
9 it over to you for discussion on next steps.

10 Historically, Medicaid enrollment and renewal
11 processes relied on in-person applications and paper
12 documentation to verify eligibility. States had
13 considerable flexibility in designing and administering
14 many aspects of this process, leading to variation across
15 states and populations.

16 As mentioned at the outset, the ACA's changes to
17 Medicaid enrollment and renewal were intended to simplify
18 and streamline those processes for all populations. In
19 doing so, there was an expectation that the share of
20 eligible persons able to successfully enroll and retain
21 Medicaid coverage would increase, and errors associated
22 with administering complex eligibility rules would

1 decrease. In addition, these provisions were meant to
2 ensure that determinations of both eligibility and
3 ineligibility would be made more quickly and at less
4 expense.

5 The ACA required states to maximize automation
6 and real-time determinations with Medicaid and CHIP
7 applications through the use of electronic verification
8 policies, simplified business practices, and the use of
9 multiple modes of application including online. The ACA
10 also gave states broader access to third-party data sources
11 through the Federal Data Services Hub and required states
12 to use these data sources to verify eligibility whenever
13 possible, instead of requiring applicants to document their
14 eligibility.

15 Federal statute and regulations now define a more
16 common approach across states for individuals to apply for,
17 enroll in, and renew coverage, but even so states still
18 have some flexibility in designing their processes.

19 MACPAC contracted with the State Health Access
20 Data Assistance Center, or SHADAC, at the University of
21 Minnesota School of Public Health to examine the post-ACA
22 status of state systems and processes used to support

1 Medicaid eligibility, enrollment, and renewal for those
2 whose eligibility is determined using modified adjusted
3 gross income, or MAGI.

4 The six study states were Arizona, Colorado,
5 Florida, Idaho, New York, and North Carolina. The study
6 assessed autoenrollment and autorenewal practices, the use
7 of electronic data sources for verification, and the degree
8 of integration with non-MAGI Medicaid populations, and
9 other public benefit programs. Interviews for this study
10 were conducted in May and June of this year.

11 So these study states took different approaches
12 to streamlining their Medicaid eligibility processes, which
13 reflected their state priorities and existing policies, as
14 well as the age and capabilities of their existing
15 eligibility systems. Some states prioritized real-time
16 enrollment and renewal, while other states prioritized
17 eligibility worker involvement in the process. All states
18 focused on the transition to MAGI-based eligibility rules
19 and the use of electronic data sources for verification.
20 They also had to balance the need for accurate eligibility
21 determinations with efforts to make Medicaid enrollment as
22 streamlined as possible, and this informed their decision-

1 making.

2 So, Commissioners, there are more details on the
3 individual states in the appendix of your materials but I'm
4 going to talk today more about the key themes that we
5 found.

6 Despite their different approaches, the responses
7 across the six states revealed several key themes related
8 to Medicaid beneficiary and program experiences. Across
9 the study states, respondents said that their combined
10 online applications support greater access to coverage and
11 reduced beneficiary burden. This is, in part, because with
12 the single application individuals can submit required
13 information just once rather than having to submit the same
14 information multiple times through different avenues.

15 The combined application can also help raise
16 awareness of other benefits for which individuals may be
17 eligible. Respondents acknowledged that while their
18 application pathways and systems are integrated from the
19 customer point of view, the back-end eligibility systems
20 are often fragmented, outdated, or complicated to maintain.
21 However, all respondents said that their state systems
22 increased the caseworker's ability to quickly and easily

1 get a holistic view of their client's program
2 participation, and this has helped to reduce or shift
3 workloads for eligibility staff, especially for those
4 serving individuals who receive multiple benefits.

5 Respondents all agreed that the system
6 connections with electronic data sources, including state,
7 federal, and proprietary data sources, facilitated real-
8 time eligibility determinations and auto-renewals.

9 States ranged from having connections that
10 allowed workers to view electronic data in a central
11 location, to having more sophisticated linkages where data
12 populate state information systems directly. In addition
13 to supporting the real-time determinations and more
14 efficient application process, these interfaces allow for
15 more timely notification to counties, meaning that in
16 county-administered Medicaid programs workers can more
17 quickly begin to work those cases that are also eligible
18 for other benefits.

19 Assistants in multiple states also praised the
20 online application together with the integrated eligibility
21 system and use of electronic data for speeding up
22 processing time. However, despite these robust rules

1 engines and electronic use of data, verifying income still
2 remains one of the biggest challenges for states, as some
3 beneficiaries, particularly those with unstable incomes,
4 are required to provide additional documentation.

5 Most respondents remarked that the efficiencies
6 gained through the data interfaces reduced the
7 administrative costs and the fluctuations on and off
8 Medicaid, thereby improving the continuity of care.

9
10 Respondents emphasized that even with the right data
11 sources, a robust rules engine to automate the eligibility
12 rules across health and non-health programs was critical to
13 supporting their streamlined determinations. Several
14 respondents explained that the systems support a quality
15 control step as well, whereby workers can review how
16 customers entered information and make corrections if
17 needed.

18 In addition, some respondents felt that it
19 supported a more efficient process, because a robust rules
20 engine was seen as supporting better customer service as
21 well. This allowed eligibility workers to focus on the
22 customer and their specific situation instead of the

1 minutiae of the program rules themselves. The respondents
2 did feel that policy knowledge was still important for
3 eligibility workers to flag areas where there may be
4 concern as people were applying for benefits.

5 So updating eligibility engines to accommodate
6 the different program requirements in one system still
7 remains challenging. Other programs often have different
8 income-counting rules or stricter verification
9 requirements.

10 States also struggled with designing a single
11 streamlined application that could collect information in a
12 straightforward, easy to understand way. Several states
13 had structured their online applications so that they are
14 dynamic, meaning that additional questions appeared
15 depending upon the information that is already entered.
16 Other states have struggled with combining their
17 application information.

18 Respondents uniformly agreed that the streamlined
19 processes, including a combined online application, are
20 helpful for people to apply for Medicaid or other health
21 and human services. However, in-person assistance remains
22 in high demand, especially for certain populations such as

1 families with multiple sources of coverage, immigrant
2 applicants, and individuals with lower computer literacy.
3 Applicants come to the state or community assister offices
4 typically because they lack computer access, have
5 difficulty understanding the application questions, need
6 help interpreting the notices, and need assistance with
7 documentation.

8 So looking forward, respondents were closely
9 monitoring potential Medicaid policy changes in their
10 states, such as Medicaid expansion proposals in Idaho and
11 proposed work requirements in Arizona. Also on the horizon
12 are changes to several key funding streams, including an
13 expiration of the Office of Management and Budget's
14 Circular A-87, which everyone should know. It's a cost
15 allocation waiver that is expiring on December 31, 2018.
16 And when that waiver expires, states will have to charge
17 human service programs for any efforts to integrate
18 eligibility, enrollment, and renewal processes across
19 health and non-health. Also forthcoming is a \$26 million
20 reduction in CMS grant funding for ACA navigator programs,
21 as well as reductions to the federal medical assistance
22 percentage for the Medicaid expansion population.

1 Four of the study states also reported
2 beneficiary confusion regarding the correspondence about
3 eligibility terminations and renewals, and three of these
4 states reported plans to either improve the readability,
5 allow notices to become more case-specific, or provide
6 assisters access to the notices.

7 States are also continuing to invest staff
8 resources and funding to improve the application and
9 eligibility systems. All six states are working to improve
10 the usability of application platforms for individuals, and
11 all were also in the process of enhancing their eligibility
12 systems, for example, through the integration across health
13 and non-health, or moving away from legacy mainframe
14 systems to rules-based systems that are modular, cloud-
15 based platforms.

16 So staff is working with a contractor to publish
17 these findings, but the Commission may have additional
18 ideas for work in this area and we would be eager to hear
19 what they are. And with that I turn it over to you guys.

20 CHAIR THOMPSON: Wonderful. I do know A-87, kind
21 of inside and out, unfortunately, so I can't imagine that
22 other people would not have spent, you know, lifetimes

1 thinking about this.

2 I just want to make a couple of points. First of
3 all, I would just say my view. We should publish this.
4 I'm not sure that there's a ton of additional follow-up
5 that kind of jumps out at me in terms of prioritizing where
6 we're spending our resources, but I think it's very helpful
7 to kind of have done this and have a state of play. This
8 is one of those areas we talked in the earlier session
9 about, you know, sometimes you've just got to keep making
10 incremental progress around some of these issues, and I
11 think that's an area where we see states continuing to
12 invest resources and so forth.

13 You know, obviously if other Commissioners have
14 some ideas about some jumping-off points for additional
15 inquiry, please jump in.

16 I just want to make a couple of comments about
17 things that I think merit reinforcement. One is the
18 importance of user-centered design in these technology
19 projects and the idea that you really have to be putting
20 yourself in the members' place, and, Leanna, I see you
21 nodding your head about the idea that, you know, some of
22 this, you know, is not intuitive, you know, the way that

1 things flow is based upon how the government side processes
2 something or the existing workflows that have kind of just
3 been built up over time rather than from the standpoint of
4 the member.

5 And, you know, just re-emphasizing that, you
6 know, when we think about any kind of modern technology
7 project today, where people, consumers, workers have to
8 navigate through a website, that element of designing with
9 the users, watching them use the websites, determining
10 where they get stuck -- there's all kinds of tools and
11 analytics that can support that. And I'm just really
12 gratified, first of all, to see, you know, some of these
13 states really embracing those concepts, and I think that
14 really pays off in the end.

15 And then, secondly, kind of the point that
16 regardless of what kind of technology, regardless of how
17 well it's designed and what you've invested, people still
18 need people. And I think just those two themes really jump
19 out at me. And, you know, it's sort of interesting having
20 this presentation on the heels of the conversation that we
21 had yesterday about, you know, work requirements and the
22 kinds of things that we think, you know, the states and the

1 federal government ought to be sensitive to. And I think
2 those are a couple of points to be brought into that
3 conversation.

4 Toby.

5 COMMISSIONER DOUGLAS: First, great report.

6 I mean, I would say, this area, we forget how
7 important this work was when we think of the modernization
8 of Medicaid, and, well, OMB's Circular 87 seems such an
9 arcane -- it was so important in terms of modernization and
10 the experience.

11 So one area is just around the consumer
12 experience from having -- if we or we think there's enough
13 out there just in terms of how its impact, the experience
14 of eligibility enrollment, from the beneficiary perspective
15 and changes. I mean, one would be understanding, for
16 example, back to where beneficiaries -- we know most of
17 Medicaid beneficiaries now have mobile phones. So what are
18 states doing in moving more to not an online, but thinking
19 this through mobile devices and changes in that structure?
20 That would be something to just understand kind of the
21 experience and how it's changing.

22 The other thing from a state perspective -- and

1 Penny and I know this was the big one as well -- we still
2 need the workers. It wasn't underlying -- and you said
3 around cost, and it wasn't clear on where we're seeing
4 changes in administrative expenditures. That one of the
5 goals, especially back to OMB Circular 87 was to reduce the
6 administrative expenditures, knowing the technology and
7 consumer ability to actually do the enrollment, whether
8 through more of an assister rather than eligibility workers
9 would change it and if any states are seeing that change.

10 MS. HEBERLEIN: So we didn't ask specifically
11 about whether or not there were cost savings.

12 We heard that states were shifting workers
13 because they didn't have to spend so much time so that they
14 could then spend time on the more complicated cases because
15 people were coming through a more streamlined process.

16 We heard that the data interfaces in some states
17 that now -- even the state that aggregated their data into
18 one computer screen -- that eased worker time because
19 instead of having to go from this screen to this screen to
20 this screen, they could see everything at once. Even
21 though they were still manually sort of approving the case,
22 they were moving it through more quickly.

1 We heard tidbits that would make you think that
2 there are administrative savings, but we didn't
3 specifically ask where the dollars associated with that,
4 where they may be coming from.

5 COMMISSIONER DOUGLAS: Maybe this is just more of
6 my own, but I feel like this is something that we should
7 dig deeper. Over time, if there are not, if we're still
8 seeing the same eligibility enrollment infrastructure, it
9 just seems something should have changed, and I'd like to
10 hear Penny or others on this.

11 CHAIR THOMPSON: Well, I would say,
12 unsurprisingly, I mean, there was a theory of the case --

13 COMMISSIONER DOUGLAS: Yeah

14 CHAIR THOMPSON: -- that said there would need to
15 be this investment, and there would be back in savings.
16 Those savings were largely technology-based, not people-
17 based, which was the idea that the ongoing maintenance of
18 those systems would be lessened in the future. So they
19 would be less costly to operate.

20 COMMISSIONER DOUGLAS: [Speaking off microphone.]

21 CHAIR THOMPSON: Right, right. I'm not saying
22 there wasn't a reflection of automation, but in the -- both

1 the regulation, federal regulation was all technology, not
2 people.

3 Unsurprisingly, I don't know that we have good
4 baselines. So when we're sort of saying what was the
5 change, I think that we've not always -- administrative
6 data has not always been reported in a way that allows CMS
7 to easily break it out and then to be able to distinguish
8 between people working on this versus that or even
9 technology pieces that support this versus that. So I
10 think it would be a very difficult task to try to really
11 pull that apart.

12 I do think it's kind of interesting that people -
13 - because I think this was the idea -- that if people were
14 released from -- and this is, of course, part of the
15 argument around technology. If people are released from
16 mechanical calculations and collections of paper and really
17 have an opportunity to devote their time to people who need
18 more assistance or education, that that would be, as we
19 used to say in my OIG days, funds put to better use as
20 opposed to a big part of this being extracting personnel
21 costs out of the system.

22 I did want to respond, Toby, to your point about

1 -- I kind of think about this as almost consumer
2 engagement, this question about how do you reach consumers.
3 There's a whole lot of reasons why in today's world, we
4 might want to be able to reach and engage Medicaid members,
5 consumers, beneficiaries, applicants, and what are the
6 methods by which people are finding success in doing that,
7 what kinds of communications and education and messaging.
8 There's a bunch of stuff around texting. It is a slightly
9 different subject than eligibility, though it could take
10 into account anything that you need to do to maintain your
11 coverage, but that may be an area worth exploring.

12 Martha.

13 COMMISSIONER CARTER: As I alluded to yesterday,
14 I seem to be sort of inserting myself in this middle ground
15 here. When the marketplaces first went into effect, the
16 community health centers received additional funding for
17 eligibility and outreach workers, and for some period of
18 time, each health center got some amount of funding. For
19 some period of time, we actually were reporting quarterly
20 in terms of the number of people who were assisted, the
21 number of people who were informed. I don't remember the
22 metrics anymore, but that funding has gotten rolled into

1 our base grants.

2 So the community health centers, the FQHCs --
3 there's a little difference, so I'm going to use community
4 health centers -- continue to get this funding to have
5 staff to interface with our patients and the community over
6 enrollment issues. There's a certified application
7 counselor designation that requires training and
8 certification that the health centers are now responsible
9 for ensuring that that happens. So there's a whole wealth
10 of information around that whole system that's somewhat
11 limited to the health centers but not because those
12 outreach and enrollment specialists are expected to go out
13 in the community and hold public information events and
14 help people enroll.

15 CHAIR THOMPSON: Alan.

16 COMMISSIONER WEIL: I thought this was really
17 interesting. I had some involvement in this topic at the
18 beginning and have been away from it for a long time, so
19 it's nice to get an update.

20 I too, Penny, struggle with what comes next. At
21 the risk of grossly overstating it, you made a few comments
22 about elements of what make it successful.

1 We just had a conversation about duals, and a lot
2 of the same elements -- time, infrastructure, resources,
3 personal touch, cross-state learning -- it's not rocket
4 science. I mean, it is rocket science, but we know what it
5 takes to build the rocket. Maybe that's a better way to
6 say it.

7 So I really view this as a success story in two
8 respects. One is the uncertainty regarding actual people
9 use notwithstanding, the progress not just reported by
10 these states, but in general, seems to me to be notable.
11 But it's also the reality that, as what you presented
12 reminds us, where states went with this was quite
13 different, despite a consistent overall need to implement
14 the MAGI rules. What it took to do that and what the
15 emphasis was in the opportunity that created was quite
16 different, and I think that's where you get some benefit.

17 So I'm not sure what to say other than I do think
18 it should be published, but I also think it's important as
19 we're looking -- sorry to turn a positive into maybe a less
20 positive, but as we're looking at questions like public
21 charge and work requirements and other things that go --
22 regardless of the merits of the policy, they go in the

1 opposite direction with respect to simplification, and if
2 we can't sort of talk about the benefits of simplification,
3 then I think it's very hard to talk about the implications
4 of things that are not as simple.

5 So that to me feels like an important lesson out
6 of this, which is sort of setting a bit of a baseline of it
7 is -- this is -- it's a complex system in many dimensions.
8 It is possible to simplify. It actually takes work to
9 simplify, but then that simplification is also fragile
10 because we don't stand in one place, and we want to do
11 other things.

12 CHAIR THOMPSON: And keep breaking it apart,
13 right.

14 COMMISSIONER WEIL: But then that has
15 consequences.

16 Somehow, I would like that to be captured --

17 CHAIR THOMPSON: Yeah.

18 COMMISSIONER WEIL: -- because I do think there's
19 a real lesson here.

20 CHAIR THOMPSON: I absolutely think there's like
21 a throughput of themes here around consumer-friendly, user-
22 focused, reducing complexity, and promoting automation to

1 free up people from spending time on mechanical, calculable
2 matters.

3 But I do think, Alan, that point, which is
4 there's always that constant strain of thinking about how
5 to maintain that kind of an approach, this happens with
6 benefits too. You get into a program, and you say, "We
7 want this." Well, then what about this tweak and add this
8 and do this? And suddenly, some of what you've tried to
9 establish falls apart. So I think that's worth continuing
10 to emphasize.

11 Any other comments from the Commissioners?

12 [No response.]

13 CHAIR THOMPSON: Let me invite public comment to
14 this subject to any others that we've tackled this morning.

15 **### PUBLIC COMMENT**

16 * MS. BRANGAN: Hi. I'm Normandy Brangan, and I'm
17 with the federal Office of Rural Health Policy at the
18 Health Resources Services Administration.

19 As you all plan your chapter on the duals, I ask
20 that you keep in mind, as this discussion did today, some
21 of the unique challenges of establishing health insurance
22 markets in rural areas.

1 HRSA's national Advisory Committee on Rural
2 Health and Human Resources published a brief in August that
3 laid out some of the challenges of rural health insurance
4 markets and some recommendations.

5 Thanks.

6 CHAIR THOMPSON: Thank you for that reminder.
7 Excellent.

8 Any other comments?

9 [No response.]

10 CHAIR THOMPSON: Martha, thank you for this
11 presentation on this subject, and we'll look forward to
12 seeing that come together in a published issue brief or the
13 chapter itself being published, however you want to handle
14 that, but I think we all agree that this is really good
15 information that we should make available to people.

16 Thank you, Commissioners and staff, for a great
17 October meeting, and we'll see everyone back in December.

18 [Whereupon, at 11:24 a.m., the meeting was
19 adjourned.]