PUBLIC MEETING

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

Thursday, December 12, 2019
9:33 a.m.

COMMISSIONERS PRESENT:

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P R O C E E D I N G S

[9:33 a.m.]

CHAIR BELLA: All right. If everyone could take their seats, we're going to get started, please.

Good morning. Thank you all for being here for our December meeting. We are going to get started with an update on MACStats, so, Chris and Jerry, thank you.

HIGHLIGHTS FROM MACSTATS

* MR. PARK: Thank you. MACStats is one of our major publications each year, and it compiles data on Medicaid and CHIP from a variety of sources and puts it all into one publication. We update these data periodically throughout the year, and at the end of the year we publish the collected set of exhibits together in a single publication. The data book for 2019 will be released next week. The full data book is available on our website, and each individual exhibit is also available, both as the print version and as a spreadsheet version as well.

I will now turn it over to Jerry to present some of the highlights in this year's MACStats.

* MR. MI: Thanks, Chris.

So MACStats is a regularly updated end-of-year

publication that compiles a broad range of Medicaid and CHIP statistics from multiple data sources, including census, enrollment, survey, and national and state level administrative data. Listed on this slide are the six sections of MACStats.

The 2019 edition of MACStats includes 11 republished exhibits which show 2013 and 2014 enrollment and spending data derived from the Medicaid Statistical Information System, or MSIS. As Chris presented in October, these tables could not be updated due to the recent transition of available data from MSIS to Transformed MSIS, or T-MSIS.

While all states are currently submitting T-MSIS data, we are still validating the data for completeness and accuracy. After we complete our assessment, we will update these tables on our website.

Key statistics of this year's MACStats show similar results to last year's. These key statistics focus on Medicaid and CHIP enrollment and spending compared to other payers, Medicaid's share of state budgets, and more. I'll discuss some of these findings in more detail in the upcoming slides.

Now, getting into the trends of the data, over the last six years, Medicaid and CHIP enrollment has increased by 26 percent. Most of this change happened in the first initial years after the bulk of ACA expansion. From July 2015 to July 2017, Medicaid and CHIP enrollment had a steady increase of about 1 percent annually. However, in the past two years, from July 2017 to July 2019, there has been an annual decline in enrollment of a little over 1 percent.

Furthermore, this graph shows growth trends in Medicaid enrollment and spending. Overall, enrollment and spending have had complementary trends, both rising and falling compared to policy changes and economic conditions, including economic recessions and expansions.

In this graph, spending for health programs is compared with spending for other components of the federal budget for fiscal years 1965 through 2018. Medicaid and CHIP's share of federal outlays has remained stable. In 2018, CHIP was 0.4 percent of the total federal outlays, showing no difference from the previous year. Medicaid's share increased slightly in 2018 to 9.5 percent of total federal outlays, which is still less than Medicare's share

at about 14 percent.

This graph compares Medicaid's share of state budgets, including and excluding federal funds. When including both federal and state funds, Medicaid's share of the states' budget increases over recent years due to the increase in federal match for the new adult group post-expansion.

However, over the past four years, when considering only state funds, Medicaid is a smaller, fairly constant share of the states' budget.

In fiscal year 2018, we see that the use of managed care continues to increase. Managed care is almost half of Medicaid spending, and over two-thirds of enrollees are in comprehensive managed care. In fiscal year 2018, drug rebates reduced gross drug spending by almost 60 percent. DSH, upper payment limit; and other types of supplemental payments accounted for over half of fee-for-service payments to hospitals. Most of the tables with enrollment and spending data broken down by eligibility group are based on MSIS data and were not updated.

Similar to last year, about 16 percent of 76.5 million full-year equivalent enrollees were considered

newly eligible adults in fiscal year 2018. Spending per full-year equivalent enrollee was less for newly eligible adults than for all Medicaid enrollees.

There were also no substantial changes in eligibility criteria in the past year. In 2018, 41 percent of Medicaid enrollees had annual incomes less than 100 percent of the federal poverty level, or $12,490 for a single individual. In 2019, 33 states and the District of Columbia, two more states than last year, are now covering the new adult group. Three additional states have approved Medicaid expansion but have not yet implemented it.

MACStats also reports on beneficiary health, service use, and access to care using survey data from the National Health Interview Survey, NHIS, and the Medical Expenditure Panel Survey, MEPS. In 2018, children and adults with Medicaid or CHIP coverage were less likely to be in excellent or very good health compared to those with private coverage. Children and adults with Medicaid or CHIP coverage were more likely to experience delayed care or have trouble finding a doctor than those with private coverage, but less likely than those who were uninsured.

Children covered under Medicaid or CHIP report

having a usual source of care, seeing a general doctor, or having a well-child checkup at slightly lower rates compared to those with private coverage, but at higher rates than those who were uninsured.

This concludes my presentation. Thank you.

CHAIR BELLA: Thank you very much.

Questions or comments from Commissioners? Tom.

COMMISSIONER BARKER: Jerry, one quick question on Slide 6. That huge spike in spending in the early 1990s, I assume that is related to DSH and before there were limits on provider taxes, that that's what caused the huge spike?

MR. PARK: That's certainly part of it.

COMMISSIONER BARKER: Thanks.

CHAIR BELLA: Other questions or comments? Chuck.

VICE CHAIR MILLIGAN: I just want to make a comment for kind of the public in general. We have a session later today around countercyclical financing, and I think some of what's underneath a lot of the data on this particular slide relates to where there can be distinctions in kind of the trend. It relates to countercyclical

financing, and I just want to give, Chris and Jerry, you an opportunity maybe to just tease out a little bit of this to help maybe set the stage for that conversation later this afternoon.

MR. PARK: Sure. I mean, because this is total spending and enrollment, it's hard to discern where certain portions of it would be related to changes in FMAP, such as --

VICE CHAIR MILLIGAN: But, for example, where there was enhanced FMAP coming out of kind of some responses with short-term increases in FMAP to help manage through some of the recessions, you do see a spike in spending that's not related to a spike in enrollment --

MR. PARK: Right.

VICE CHAIR MILLIGAN: -- because it was a way of mitigating some of the stress caused by the fact that states were seeing enrollment growth at the same time they were seeing their own revenue shrink at the state level. So I do think that part of the reason it's not exactly perfectly aligned is there have been federal policy responses to how to deal with recession trends that can stress state budgets at the time that enrollment is

growing.

So I think that's just a little bit of a takeaway underneath some of the high-level trend here that might be worth just flagging to help kind of motivate the discussion a little bit later today.

MR. PARK: Yeah, and I just advanced to Slide 8 where we show share of state budgets. Around the 2010 period, you can see that the state budget including federal funds went up. But for just state-only funds, it went down, and so that's one thing that's driving that discrepancy there.

VICE CHAIR MILLIGAN: Thank you.

CHAIR BELLA: Chuck's just trying to plant a teaser to keep people in the audience excited about the future discussion. Tricia.

COMMISSIONER BROOKS: Yeah, on Slide 12, could you just say again what the source of that data is and also if there's real data that's going to be in MACStats so that we can see if it's just a marginal difference or more substantial?

MR. PARK: Sure. All of this data comes from two surveys, either the National Health Interview Survey or the

Medical Expenditure Panel Survey. Where we've kind of said they're different does denote a significant -- like a test of significance, but we do provide the actual value. So you can see that, you know, in a lot of cases, this may be only a few percentage points on some of these variables between Medicaid and private insurance.

EXECUTIVE DIRECTOR SCHWARTZ: And these are all presented in the MACStats as point estimates. We don't have a trend on these.

CHAIR BELLA: Any other questions or comments?

[No response.]

CHAIR BELLA: All right. You said it's coming out the 18th?

MR. PARK: Yes.

CHAIR BELLA: Next Wednesday.

MR. PARK: Next week, on the 18th.

CHAIR BELLA: Perfect. All right. Thanks very much for the update.

[Pause.]

CHAIR BELLA: All right. We are now going to turn our attention to a proposed rule that the agency released last month on fiscal accountability in Medicaid.

Rob and Moira are going to take us through that rule.

I'm going to ask that we start with -- once they're finished, we start with technical questions or clarifications from the Commissioners before we get into a discussion of the substance or potential areas of comment for the Commission. So this is a very meaty topic, and we appreciate what you're about to share with us. Thank you.

REVIEW OF PROPOSED RULE ON SUPPLEMENTAL PAYMENTS AND FINANCING

* MS. FORBES: All right. So on November the 18th, CMS issued a proposed rule to increase federal oversight of Medicaid fee-for-service payments and financing policies, and these are topics the Commission has discussed many times and made recommendations on. So I'll quickly walk through the background and hit some of the highlights on Medicaid payment and financing policy as it relates to the issues covered in this proposed rule, and then Rob will go through the proposed provisions of the rule in-depth and then discuss some potential areas where the Commission may want to comment.

In fee-for-service, states have broad flexibility to design their own payment methods. The two broad

categories of payments are base payments for services and supplemental payments, which are typically made in a lump sum for a fixed period of time. States vary the mix of base and supplemental payments that they make as well as the overall level of payment. Supplemental payments can include disproportionate share hospital payments, which, sorry, we're not really talking about right now, though Rob's here, and also upper payment limit or UPL supplemental payments. UPL payments are lump sum payments that are intended to fill in the difference between fee-for-service base payments and the amount that Medicare would have paid for the same service. If base payments are below the UPL, states can make UPL supplemental payments to make up the difference. In the aggregate for each class of providers, base and UPL payments for services can't exceed a reasonable estimate of what would have been paid according to Medicare payment principles.

Now, on financing, which is a shared responsibility of the federal government and the state, funding for the non-federal or state share of Medicaid comes from a variety of sources. At least 40 percent must be financed by the state from general revenue. Up to 60

percent can come from local governments through intergovernmental transfers, which includes transfers of funds from another governmental entity such as a county or other state agency, and through certified public expenditures where a governmental entity or provider incurs an expenditure and certifies the funds expended are public funds that cover the cost of the service.

States can also impose health care-related taxes or provider taxes, which are taxes where 85 percent of the tax burden falls on health care providers. States can use the revenue as a non-federal share of Medicaid payments if the tax meets certain conditions, including being broad-based and uniform, and assuring the providers are not held harmless.

Each state makes its own decisions regarding how to finance its share of the Medicaid program. As the Commission has discussed before, the extent to which states rely on funding sources other than general revenue varies considerably across states and can be influenced by states' traditional sources of general revenue and approaches to financing health care for low-income individuals.

Both Congress and CMS have taken steps over time

to tighten or clarify the rules around Medicaid payments and financing, sometimes because of evidence of state excesses, sometimes in an effort to control federal spending by limiting states' ability to make expenditures that qualify for federal contributions. So this is a new proposed rule to increase federal oversight of Medicaid fee-for-service payments and financing policies which aims to address CMS concerns about arrangements that it views to be inconsistent with Medicaid payment principles.

So I'll turn it over to Rob to walk through the actual proposed provisions.

* MR. NELB: Great. Thanks, Moira.

So I'm going to begin reviewing the provisions of the proposed rule in three parts, starting with some of the proposed changes to fee-for-service payment policy.

First, the rule proposes to limit approval of UPL payments to three years at a time and add some new review requirements for CMS.

Specifically, states must describe the specific Medicaid objectives that UPL supplemental payments are intended to address. They must tie those objectives to the statutory goals of efficiency, economy, quality, or access.

In addition, in order to renew UPL payments, states would be required to submit an evaluation of whether the payment has met its objectives. This is different from current law under which UPL payments are improved indefinitely, and states don't have to describe exactly what the goals of the payments are.

This new requirement is similar to the review process that CMS has put in place for directed payments in managed care, which we talked about at the Commission's September public meeting. In general, directed payments are required to advance at least one of the goals of the states' managed care quality strategy, and states are expected to develop monitoring plans to examine how well they do so.

In thinking about how this new UPL payment review process may work in practice, it might be instructive to consider the experience so far with directed payments. As I shared in September, when we took a closer look at some of the directed payment arrangements that had been approved so far, we found that many of them were intended to advance the goals of access. However, in the pre-prints that we reviewed, there were very few measures of access related to

the providers that the payments were being targeted at. And so we haven't yet seen any evaluations of the directed payment program so far, but the lack of sort of clear measures and the monitoring plans suggest that at least in the initial phase there may not be too much for CMS to evaluate.

Another proposed change in the rule is a new limit on supplemental payments to physicians and other practitioners. Physicians are not subject to the same types of UPL requirements that apply to institutional providers like hospitals or nursing facilities. Instead, CMS currently limits payments to these providers based on the average commercial rate, which is generally much higher than what Medicare would have paid.

In FY2017, states made a total of $860 million in supplemental payments to physicians, and most of these are targeted to academic medical centers that are affiliated with state universities.

In the rule, CMS expresses concern about the growth of physician supplemental payments in recent years and is proposing a new limit on these payments, specifically proposing to limit supplemental payments to

these providers to 50 percent of the base payment rate or 75 percent for physicians located in rural or health professional shortage areas.

CMS estimates that this provision could potentially reduce payments to providers by up to $222 million a year. However, states could offset the effects of this new limit by increasing base payments to physicians instead.

The next payment policy I want to highlight is CMS' proposal to codify some of its existing guidance on ways that states can calculate the UPL. Specifically, CMS proposes two methods: a payment-based method which is based on what Medicare would have actually paid for the service, and the other is a cost-based method based on Medicare cost principles.

As the Commission has previously noted, for some types of providers like hospitals, Medicare payments to hospitals, for example, are typically below hospital costs, and so it's worth noting that the cost-based method may result in a UPL that is higher than what Medicare would have paid.

As part of the new regulations, CMS is also

proposing to explicitly define the classes of providers that the UPL applies to. Each class of providers is subject to a different UPL limit, and the three classes of providers in statute are state government, non-state government, and privately owned providers.

In the proposed rule, CMS notes that it will evaluate government ownership based on the totality of circumstances, and this is intended to avoid situations in which public providers buy or lease private providers but don't actually run the facility.

As we talked about at the September public meeting, this type of arrangement has been used in some states to increase nursing facility supplemental payments to public providers.

Next, let's review some of the proposed changes to Medicaid financing policies. These changes affect the financing of payments in both fee-for-service and managed care, so kind of Medicaid spending more broadly.

First, the proposed rule makes several changes related to health care-related taxes. In order to understand these changes, it's helpful to review some of the current rules that apply for health care taxes.

So, in general, states are permitted to use tax revenue to finance the non-federal share of Medicaid payments; however, special rules apply when that tax revenue comes from health care-related tax, which is defined as one on which 85 percent or more of the burden falls on health care providers or payers.

In general, health care-related taxes are required to be broad-based and uniformly applied; however, states can apply for waivers in order to target taxes to particular providers if they meet specific statistical tests in regulation.

In addition, states cannot directly guarantee that providers are held harmless for the taxes that they pay by, for example, ensuring that payment to providers are directly correlated to the tax that the provider pays.

However, states can indirectly guarantee that most providers receive payments that cover most of the tax that they pay as long as the tax rate is less than 6 percent of net patient revenue. This threshold is sometimes referred to as the provider tax safe harbor.

Under the proposed rule, CMS makes a number of changes to the regulations defining permissible health

care-related taxes. Some of these changes are described as codifying existing policy, but some could be interpreted as new requirements.

So, first, CMS notes that health care-related tax rules apply to taxes imposed on health insurers as well as taxes that may apply to a broader class of entities, but generally have a higher burden on health care providers.

Second, CMS proposes a new test to evaluate waivers of the broad-based and uniform standards. Specifically, CMS will evaluate whether the tax places a higher burden on providers with a high Medicaid activity, so, for example, having more Medicaid days.

This new test applies regardless of whether -- it applies in addition to the statistical tests that are already in regulation. So it's another standard that states must meet.

Also, similar to the changes that I talked about regarding UPL payments, the propose rule proposes to limit tax waiver approvals to three years at a time. After three years, states could request to renew their tax waiver, but they must submit updated data showing that they continue to meet the regulatory standards.

Finally, CMS proposes to evaluate whether a direct guarantee exists based on the net effect of any direct or indirect payments that a provider receives. This provision is intended to avoid situations in which providers pass supplemental payments from one provider to another through a variety of indirect payments, that ensure that no provider is worse off because of the tax.

However, it's worth noting that the net effect standard described in regulation is pretty broad in its description, and it could be interpreted as applying to other types of circumstances as well.

Similar to the proposed net effect standard for evaluating hold harmless provisions for health care-related taxes, the rule proposes a net effect standard to evaluate whether donations from private providers hold IGT entities harmless.

For example, a private provider may take on additional uncompensated care burden that was previously covered by a public hospital, and this could be viewed as a -- this in-kind provision of services could be considered a provider donation if that public provider is providing IGT funds for Medicaid payments to the private provider.

CMS describes this policy as codifying its existing policy, which it described in the 2014 state Medicaid director letter. However, it's important to note that in enforcing this policy, CMS has encountered some resistance from states who have challenged CMS's policy in court.

For example, there was a recent challenge from Texas around this provider donation policy that was recently reviewed by CMS's departmental appeals board. The departmental appeals board ultimately sided with CMS saying that it could enforce this net effect standard, and that's where some of the language in the regulation comes from. However, it's still important to note that since CMS is changing its regulation in this area, there's still sort of an ongoing dispute over whether this net effect standard is new or whether it's just codifying existing policy.

Lastly, one other area to mention in terms of local government financing is that the proposed rule codifies CMS's policies for certified public expenditures. Specifically, CMS clarifies the processes that states must use to ensure that CPE-financed payments do not exceed costs. For example, providers have to use Medicare cost

reports where available, and there's a process to sort of reconcile final payments to costs.

Consistent with the proposed hold-harmless provisions, the rule proposes that providers be able to retain the full amount of Medicaid payments for services. This provision is intended to limit the ability of states to charge administrative fees for IGT or CPE transactions.

In addition, it aims to limit some of these associated transactions that I was talking about that result in returning tax or IGT payments to providers in ways that hold them harmless for the payments.

Last but not least, I will talk about some of the oversight policies that CMS is proposing that relate to both payments and financing.

So, first, the rule proposes that states report provider-level data on supplemental payments and provider contributions to the non-federal share of these payments. This provision is focused on providers that receive UPL supplemental payments or Section 1115 waiver supplemental payments.

To enforce this requirement, CMS proposes to withhold federal funds for states that do not submit

complete and accurate data.

CMS is proposing creating a new reporting structure for this data because the types of data that it's asking for are not currently available in existing data sources.

So to help you better compare the proposed rule with some of the existing data sources, this table illustrates the various types of data that are in some of these current systems and the proposed rule. It's a bit complicated, like all things Medicaid payment, but I'm going to try to walk you through it from left to right.

First, on the left column, we have the CMS-64 expenditure report, which is the quarterly report that states submit in order to claim federal matching funds. On the CMS-64, we have aggregate, state level, fee-for-service payment data, but we don't have information on managed care payments for particular services. This CMS-64 expenditure report does include information on capitation payments in general but doesn't include information about how managed care entities spend those funds on particular providers.

Second, there is the Transformed Medicaid Statistical Information System, or T-MSIS. T-MSIS includes

claims-level data on base payments to providers, but it doesn't appear that it will be collecting complete data on supplemental payments.

In the sort of data dictionary for T-MSIS, there is an option for states to submit information on supplemental payments, but CMS notes in the proposed rule that these fields are generally incomplete and not accurate. So it doesn't propose to rely on T-MSIS data to collect the types of information that it's interested in.

Third, there are DSH audits which are submitted for hospitals that receive DSH payments, which is about half of hospitals nationwide. For these hospitals, we do have information about provider-level payments, although some types of payments are lumped together. However, we don't have information on hospitals that don't receive DSH payments.

Under the proposed rule, states would submit provider-level data for all providers that receive UPL or Section 1115 supplemental payments. So this would include some hospitals that receive UPL payments but don't receive DSH payments, and it would also include other providers that are subject to the UPL, such as nursing facilities.

The proposed rule is focused on reporting for fee-for-service, and it wouldn't include information on managed care payments to providers.

Also, it's worth noting that based on our review, it's a bit unclear about how graduate medical education payments might be reported. In some cases, these GME payments are made like fee-for-service UPL payments, in which case they probably would be reported, but in some cases, GME payments are made in ways that are more similar to a managed care-directed payment. So, in that case, they probably wouldn't be counted.

Payment data, of course, is just one-half of the picture. The proposed rule also aims to collect information about how these payments are financed, and to help you understand that, this table illustrates some of the financing data that's in current systems and the proposed rule.

As you can see, we don't have much information today. The CMS-64 report does include an option for states to report payments that are financed by health care-related taxes, but in our review of these data, we have found them to be largely incomplete.

T-MSIS also has some data fields that could potentially be used to collect data on the non-federal share of payment, but they seem to be incomplete. We haven't yet reviewed these data fully for their accuracy.

So the proposed rule, of course, would collect information on provider contributions to the non-federal share, and it's just worth noting that the way this is designed, it's a little bit different from how financing data might be reported in something like the CMS-64 or T-MSIS. For example, if there's a provider that pays $100 in taxes but receives $70 in Medicaid payment, under the proposed rule, we'd be getting information about the full $100 of taxes that the provider pays rather than just looking at the $70 in payments and thinking about how that payment was financed.

All right. Another proposed oversight change has to deal with recouping of DSH overpayments. Specifically, the proposed rule outlines a series of changes that are intended to make it easier for CMS to recoup DSH payments that are made in excess of hospital uncompensated care costs. Specifically, the proposed rule requires DSH auditors to better quantify overpayments and then

streamlines the timing for recoupment, specifying that the CMS process will begin once an auditor submits a finding that there was a DSH overpayment.

Based on our review of 2014 DSH audits, we found that about 419 hospitals appeared to receive about $2.6 billion in DSH overpayments. This is about 14 percent of DSH hospitals and about 14 percent of DSH payments.

However, when thinking about the potential effects of this proposed rule, it's worth noting that most states have provisions in their state plan that allow them to redistribute, DSH overpayments to hospitals that did not receive a DSH overpayment. So it's likely that some of these provisions of the proposed rule will more affect sort of the distribution of DSH payments to providers rather than affect the total amount of DSH payments that are made.

Finally, the proposed rule codifies CMS's existing guidance requiring states to demonstrate compliance with the UPL annually.

CMS provides two options for states. They can submit prospective estimates of what they plan to spend in the coming year, or they can submit retrospective analysis based on their actual spending.

As you may recall, MACPAC reviewed state UPL demonstrations last year and found large discrepancies between the data that states reported on their UPL demonstrates and actual spending that was reported on CMS-64 expenditure reports. This finding led to a Commission recommendation that CMS establish process controls to ensure that UPL data are accurate and complete.

However, in the proposed rule, CMS does not appear to propose many changes to its actual UPL demonstration process. In particular, there's no process to reevaluate the UPL if actual spending is different from projected spending.

So now that I have reviewed some of the main provisions of the proposed rule, I will now highlight a couple potential areas for Commission comments.

CHAIR BELLA: Rob, can we pause right here --

MR. NELB: Yeah. Oh, yes.

CHAIR BELLA: -- since you've gone through all of that? And let's see if we have technical questions, areas of clarification. That was a lot. You both did it in a very user friendly way, to the extent that this can be user friendly.

I ask the Commissioners for questions or clarifications before we get into discussion of potential areas of comment. Tom?

COMMISSIONER BARKER: Thanks, Melanie.

Rob, that was a fantastic presentation. Thank you very much. It was really helpful. I read this rule very closely, and you picked up things that I had not picked up, so thank you very much.

I had a question on Slide 19, recouping DSH overpayments. So my question is in the proposed rule, if you will recall, there was litigation over how CMS determined whether or not a provider was overpaid for DSH by measuring their uncompensated care cost, because CMS issued those FAQs that were challenged. And because CMS lost, I think, four or five appellate decisions, they just basically backed down.

So overpayments under this rule, I'm assuming, is under policies that don't use those FAQs; is that correct?

MR. NELB: So this will apply to overpayments. After the FAQs, then CMS issued a proposed rule --

COMMISSIONER BARKER: Right.

MR. NELB: -- that clarified its treatment of

third-party payments for the purpose of uncompensated care costs. I believe that change --

COMMISSIONER BARKER: But didn't that --

MR. NELB: -- applies for DSH audits starting in 2017 going forward.

So the finding that we have here for 2014 is some of those funds may not end up being recouped because of the uncertainty.

In doing this analysis, we looked at the 2014 DSH audits rather than the 2015 DSH audits because 2014 audits show uncompensated care calculated based on CMS's new rule, and so that's sort of more likely what the amount of overpayments may be in future years. But it really won't kick in. I believe it's 2017 or once that final rule takes effect.

COMMISSIONER BARKER: Thank you.

CHAIR BELLA: Kisha?

COMMISSIONER DAVIS: Thank you for this very detailed analysis.

Can you just talk a little bit more about base payments and adjustments in that and states could do it, how this supplemental rule affects that or what you think

the trend might be for states to do that?

MR. NELB: Yeah. It's a good point.

So a lot of the fee-for-service provisions in the rule apply to supplemental payments but don't affect state's ability to make base payments to providers.

In our review of various compendia we've done of base payments, there's a lot of variation that states can do. With a base payment, the payment is based on payments for services, so providers that serve more Medicaid enrollees generally receive more base payments. But states do have a lot of flexibility in being able to maybe adjust base payments rates for different classes of providers. So public or private providers or perhaps rural providers can get paid at a different rate than other types of providers, and those sorts of payment adjustments are not classified as a supplemental payment because there are adjustments to the base rate. But it is possible to use those sorts of adjustments to target payments to particular providers in the same sort of way that a supplemental payment would.

So to get at your question of what might be some of the implications, I think with the physician, the new limit on physician supplemental payments, there may be some

effort by states to look at converting some of those supplemental payments that are in excess of the limit and figure out a way to put that money into base payments.

I think we found from our previous reviews of hospital payments that even though it's theoretically possible to put some of the supplemental payment funding into base payments, but it's complicated, and so states need time to adjust to that. And it's just a little more challenging to maybe target the funding to particular providers in ways that you might -- that are a bit easier to do under a supplemental payment.

CHAIR BELLA: Toby, then Darin, then Tricia, then Peter, then Fred. All right.

COMMISSIONER DOUGLAS: So a couple questions. First, on the provider taxes, can you explain a little bit more the rules around the differentiation on Medicaid burden versus non-Medicaid. For example, for hospital taxes, a lot of times the days are -- there's different rates for a Medicaid inpatient day versus a commercial. So what will this rule do with that, those types of -- but then go to a waiver, broad-based uniformity?

MR. NELB: So the new test applies to taxes that

are not broad-based and uniform, so there's only a subset of provider taxes that require this waiver because they are targeting the payments to only particular types of hospitals in the state, for example, that have to pay the tax.

The rule talks about this new standard related to Medicaid activity, and so that has to deal with -- so, for example, if you were taxing providers based on their Medicaid days, that would be a tax that is sort of based on your Medicaid activity. You could still have a tax that is based on non-Medicaid activity, so a tax based on maybe the total number of days at a hospital, that is both Medicaid and commercial or Medicare, you know, that's designed in a way that maybe captures the relative size, that larger hospitals pay more taxes or something. But, yes, CMS is adding this new test that is to get at taxes -- to limit the ability of states to do taxes that are based on things like Medicaid days or Medicaid patient revenue, anything that's sort of related to Medicaid activity.

COMMISSIONER DOUGLAS: So is it Medicaid days $10 and commercial is $100, that would no longer be permissible?

MR. NELB: Most likely, yeah. And so, yeah, I believe most likely. If the tax was broad-based and uniform, you wouldn't -- that test wouldn't apply. So let's say perhaps if it applied to all hospitals in the state, there may be some little more wiggle room there. But, yeah, in general, the provision is intended to discourage the use of those types of arrangements.

COMMISSIONER DOUGLAS: And CMS said that there was -- at this point that they did not see any financial impact then of this?

MR. NELB: Yeah. So in quantifying the impacts of the rule, CMS only notes the potential impact of the new limit on physician supplemental payments. It doesn't quantify any of the potential effects of some of the financing provisions. As you think about that, yeah, there may be some effect if a state is doing some sort of financing arrangement that is now no longer permissible.

COMMISSIONER DOUGLAS: It just seems puzzling that they wouldn't have put, given they have reviewed just in the last few years several states that have done that type of change between Medicaid and commercial, that there is no financial impact.

MR. NELB: I think that might be a potential area for comment that we could think about. And as you think about the potential effect, I think I note in the memo, you know, CBO, for example, has looked at -- and we've done work, too. If a state's no longer able to tax providers in the way that they could, what's the likelihood that they would replace that payment with state general revenue or other sources of funding? And I think in CBO in its analysis basically assumes that maybe only about half of the tax would be replaced by state general revenue. So it is likely that if a tax was determined to be impermissible under the new rules, that it would result in a reduction in payments to providers.

CHAIR BELLA: Darin.

COMMISSIONER GORDON: Thanks as always. This is helpful. A couple of things that I just want to make sure I'm understanding correctly.

So the three-year limit to review, that is consistent with what was required on the managed care side? I just didn't recall that that was a three-year review period.

MR. NELB: Directed payments under the current

regulations actually have a one-year -- they have to come in each year whenever a state's submitting its new managed care contract. I guess in 2018 there was a proposed rule to change and allow for multi-year approval of these delivery system reform type directed payment arrangements, so this effort to kind of allow a little more time, but it doesn't say three years.

COMMISSIONER GORDON: But that's on the directed payment, so if it's not going through the health plan, then that's what -- supplemental payments are outside of health plans, so that's why I was wondering, because it's not being reviewed at the contract period. But that's help that there's an effort to try to -- I just didn't realize there was a three-year period is what their goal was, and you're saying that's what they're trying to get to. That's not where they're at today.

MR. NELB: That's the plan, on managed care the directed payments for at least multi-year approval.

COMMISSIONER GORDON: Okay.

MR. NELB: But, yeah, under current law, UPL payments are approved indefinitely, so there's --

COMMISSIONER GORDON: Okay. That was my

understanding.

Also, just to clarify, on the supplemental payments, you talked about limiting it to the 50 percent of base payment rates and 75 percent rural areas, so I guess presumably that's a retrospective review, because I can't think of how one would do that live.

MR. NELB: CMS doesn't talk about some of the operational considerations, but that's something to think about. There is no -- in terms of the UPL demonstration requirements, there is no UPL requirement that applies to physician supplemental payments. Since there is no UPL, it's not really clear how CMS would enforce it.

COMMISSIONER GORDON: The reason I ask is that clearly just sets up another situation where there's going to be a recoupment of funds at some point whenever an audit's done to be able to test that.

Then, lastly, on the proposed tax side rules, it said that CMS will evaluate whether the tax places a higher burden on providers with high Medicaid activity. Is that defined, or is it just merely if it's a dollar more than what it is for the other payers, that constitutes higher burden?

MR. NELB: CMS does propose to define that. They both define sort of what Medicaid activity is. I'll have to go back to confirm, but the main thing CMS is getting at is where the parameters of the tax are defined in a way that targets providers with high Medicaid activity, so perhaps some of the situations Toby was talking about where like the tax itself is -- in the parameters of the tax, a high Medicaid provider would have to pay more, not just that when you do the math that it happens that a Medicaid provider ends up paying a little bit more than a non-Medicaid provider.

Chair Bella: Okay. We have four people, and then I'm going to ask that we kind of run through these quickly so we can get to areas of recommendation. So Tricia, Peter, Fred, and Stacey.

COMMISSIONER BROOKS: My question is about -- you know, we need the data, obviously, in order to make informed decisions about what changes should be made. So to me, to some extent this rule should be in two parts.

But I'm curious, and this may be a question for Chris as much as it is for you, Rob, and thank you for this because it's mind-boggling. What's the readiness of state

systems to report the data that's needed and of CMS to collect that so it can be analyzed? We've been waiting for performance indicators on Medicaid for four years, and T-MSIS is not giving us much of that data other than enrollment and application volume and now MAGI application processing time. So I'm just curious. Are systems ready to collect this data so that we can actually do something with it?

CHAIR BELLA: And if we're not sure, we could save this as a potential comment that we might want to make as a consideration of state readiness and state capacity.

MR. NELB: I guess all I can say is the proposed rule doesn't talk that much about state readiness. It includes estimates of the potential burden on states of some of these various requirements and doesn't assume that there would be that much burden as a result of the new reporting requirements. But I think that's an area you may want to comment on.

And then in terms of CMS' capacity, there are legitimate questions there. It may be worth noting CMS is in the process of sort of updating its financial management system called "MACFin" that anyway would -- it's sort of a

new system that would build off on the way that the 64 and other things get reported. But it's still in the early pilot phases, and as we know from the experience with T-MSIS, these things do take a while.

CHAIR BELLA: Peter.

COMMISSIONER SZILAGYI: Yeah, a quick question on the supplemental payments, and thanks for your great presentation. I think you mentioned quickly that CMS' estimates of $222 million decreased payments, maybe more among academic medical centers, do you know how much of this is children's hospitals? And how much of the $222 million would be actually in academic medical centers? And the reason I ask is because this is where a lot of the children with complex care needs are seen and where adults with very serious diseases are seen.

MR. NELB: So the $222 million estimate came from CMS' review of state-submitted these sort of UPL-like demonstrations for physicians. We don't have access to that, so we can't really go behind the numbers to see who would be affected.

A few years ago, MACPAC did do a compendium of physician payment policies in fee-for-service, and so we

have a sense of the different types of providers that are targeted by supplemental payments, and so we can take a look at that. At least the state plans just generally describe academic medical centers more broadly and don't tie it to particular services that they provide, but obviously many of these academic medical centers do provide a lot of complex care for kids as well as adults, and it's hard to tease out exactly what the money is being used for.

CHAIR BELLA: Fred.

COMMISSIONER CERISE: Thanks for the summary, guys. On the questions of classifying providers and then on some of the provider tax and the mitigation strategies, these two concepts of totality of circumstances and then net effect, which are very broad, and I'm just wondering how much specificity you can expect to see around that, because we know that there are existing arrangements that are being thought of when CMS uses that language. And so would you be able to kind of go down the list of what states are doing in particular categories and say, no, it doesn't fit; yes, it fits? How specific will we be able to understand those concepts?

MR. NELB: So the short answer is that, you know,

we don't have -- the rule doesn't provide enough information on exactly how CMS is going to apply the new rules, and I think at our level we don't have a full understanding of how all these different arrangements are working to know exactly which states would be most affected.

I would say the regulations do provide a little bit more detail on sort of the definition of public versus private provider. It's a little bit more spelled out and related to taxing authority and various things. That's a little bit more spelled out than the net effect standard for hold harmless, which is whether there's any "reasonable expectation that a provider would receive any or all of the payment back," and the net effect standard applies to both written and unwritten arrangements. So it's pretty broadly worded, and because of that it's a little hard to know what counts and what doesn't.

CHAIR BELLA: Stacey,

COMMISSIONER LAMPKIN: Yeah, I'll try to be quick. Thank you. My question relates to the new limit on the physician sup, and I thought I was tracking until the dialogue with Darin, and then I got confused, so I want to

clarify.

So is this new limit the 50 percent of base or 75 percent of base essentially replacing the average commercial rate benchmark that has been in place?

MR. NELB: It appears that it's just new regulatory text, so there's no deletion of the old one. I could go back to -- the previous average commercial rate was not actually in regulation, but it was sort of CMS' practice when it was reviewing plans. CMS has this general authority to assess whether payment methodologies are efficient and economic and things, and so in that practice it has looked at average commercial rates as a benchmark for assessing whether payments are economic and efficient, and so it's likely that it would continue to do so.

But what it's really try to get at in this rule are the supplemental payments that basically just calculate the difference between the average commercial rate and the current rate and then pay that out as a lump sum.

COMMISSIONER LAMPKIN: Okay. So the ACR could still be the benchmark that is used with this new regulatory language?

MR. NELB: For base payments.

COMMISSIONER LAMPKIN: Right. Okay. Thank you.

CHAIR BELLA: Okay. We are now ready to turn to potential areas of comment.

MR. NELB: All right. Great. So let's see. There are obviously a lot of different provisions in the proposed rule, but I'll just outline a couple potential areas for comment.

First, the Commission could note the extent to which the proposed rule aligns with MACPAC's prior recommendations on provider-level data and UPL oversight.

On one hand, the rule does take several steps to address MACPAC's prior recommendations. However, some aspects of our prior recommendations are not fully addressed.

For example, MACPAC recommended that CMS collect and report data on all types of payments for all hospitals that receive them, but the proposed rule doesn't include information on managed care payments, and it doesn't include information on payments to providers that don't receive UPL supplemental payments.

Also, regarding the UPL, as I mentioned, CMS doesn't appear to propose any process to ensure that actual

UPL spending data is used to enforce the UPL requirements. And so as a result, there may continue to be some of these discrepancies between what states report on their UPL demonstrations and what they actually spend.

And, finally, for both the payment and UPL data, MACPAC has recommended that these data be made publicly available, but CMS has not proposed to do so.

Another general area where the Commission could comment is on the general level of federal oversight proposed. So the proposed rule obviously provides an opportunity for increased federal oversight of Medicaid payment and financing policies. But as I've noted, it's a bit unclear about how some of the new provisions would be applied. And without more clarity, the rule may have an unintended consequence of creating some confusion for states and providers.

In particular, I've noted that it's not clear how CMS will evaluate whether supplemental payments advance their statutory goals, and also that net effect standard I talked about is pretty broadly worded, and it's a bit unclear how that may be applied.

As the Commission thinks about the appropriate

level of federal oversight, it might be helpful to compare CMS' proposed approach in this rule to its previous proposal this past summer to rescind access monitoring requirements because CMS viewed them to be too burdensome for states.

The Commission could also make some general comments about the potential effect of the proposed rule on providers. As I noted, CMS estimated that the rule would reduce physician supplemental payments by up to $222 million a year, but it doesn't quantify the effects of other provisions to the proposed rule. Although CMS describes many of these provisions as enforcing prior policy, the increased federal oversight proposed is likely to result in reductions in payments to some providers.

To the extent that the Commission is concerned about the potential effects of the proposed rule on providers, the Commission could suggest several ways for CMS to mitigate the effect. So, for example, CMS could wait to apply some of the new rules until it collects more data about their potential impact. CMS could also delay the implementation of some of the new requirements to allow states and providers more time to adjust their payment

policies.

And another approach would be for CMS to reaffirm the requirement for states to review access before reducing payments to providers. This provision is part of current Medicaid regulations, but as I mentioned, CMS proposed to rescind the requirement in July.

Finally, there are several technical comments that the Commission could make on various topics that CMS requested comment on and which we have previously examined. Some of these potential areas for comment are listed here. In the interest of time, I won't review each of them, but I'm happy to discuss them further if you have any questions or concerns.

That concludes our presentation for today. Comments are due January 17th, which is before the next Commission meeting. As a result, if the Commission decides to comment, we will prepare a letter reflecting the discussion at this meeting.

We also welcome your feedback on potential areas for future Commission work based on some of the changes and concepts described in this proposed rule. Thanks.

CHAIR BELLA: Thank you both.

So just to start out, I think there are two kind of broad questions before us. One is, do we comment? The second is, if so, then where are we commenting?

Given the interest of the Commission and sort of the relevance and significance of this rule, I think it is appropriate for the Commission to comment. Does anyone have any concerns that we can just sort of take that off the table? Is there anyone who wants to make a case for not commenting?

[No response.]

CHAIR BELLA: Great. So the decision is we will be commenting.

We need to now refine the areas of focus, and there are many, many things we could say about this. I would say that we want to be judicious in thinking about impactful comments that we really think are glaring opportunities to help the agency as it moves forward with this rule.

So, with that, we will open it up for comments, starting with Toby.

COMMISSIONER DOUGLAS: So, Rob, I like the areas that you outlined for areas of comment.

I mean, I think just fundamentally, what I would propose is that we recommend that they wait to apply the new rules until it collects more data and for a couple of reasons, as you lay out. There's just fundamental questions about implications on access, so for the supplemental payments, for physicians. While they align it with commercial rates and the growth, there's no connection back to alignment with access and what are sufficient increases necessary for access and especially as Peter laid out for specialty services for children or other areas.

Then on the provider taxes, there's just so much more data that could be collected on the implications on the waivers that have been approved, whether it's on hospitals, nursing facilities, managed care plans, to make sure there's a clear understanding of the implications that the net effect will have on access. This is not looking through that lens enough, and data is essential before we make such dramatic changes.

CHAIR BELLA: Martha, then Tricia.

COMMISSIONER CARTER: This is pretty much going in the same direction.

I think our concern is do no harm to access for

Medicaid beneficiaries. So I'm not sure -- those of you who have more insight into this could comment on whether you want to say it should be delayed, but I definitely want to express our concern for access to care, how these provisions could affect payments to providers, which would then affect access to care.

CHAIR BELLA: Tricia?

COMMISSIONER BROOKS: So I certainly would agree that delaying implementation of the rule until the data is there would be important, but it seems to me that we'd be approving changes that, if we were to actually see the data, might not be the changes we would want to see.

So going back to that comment I made previously about it seems like this really should be two rules, one, let's get the data. Maybe we don't even need a rule of that. Evaluate the data, and then decide what needs to change.

But I think there's another option for the Commission, and that is for us to urge CMS to move the comment period out, to give more time, because as best I can tell in the circles that I travel in, a lot of people are having a hard time getting their head around this rule

and what the implications are for access for beneficiaries, for providers, and for others in this system.

CHAIR BELLA: Peter, then Stacey.

COMMISSIONER SZILAGYI: Yeah. I just want to support what Toby and actually pretty much everybody has said.

In the child world, 5 percent of kids account for 50 percent of the Medicaid costs, and more and more of those 5 percent of children are not being hospitalized. They're seen in outpatient settings, and we're trying to keep these kids out of the hospital. And I'm worried that even though 222 million seems small, a high percentage of that will fall on child health providers and children's hospitals or children's services within general hospitals and the same in the adult world.

So I do think that we should wait for the data, and I suspect what the data will show is that this may not be -- that there would be major problems with access.

The other issue is that many of these 5 percent of children are not able to be taken care of in other settings, outside of academic hospitals, and these are children who are on ventilators and all sorts of very, very

complicated -- and there's just no other providers to see them. So I think there's a potential access problem here.

CHAIR BELLA: Stacey?

COMMISSIONER LAMPKIN: A question for my colleagues on the comments about get the data and then make the other provisions. Are we being specific there to the new limits and the tax changes? Is that what we're applying that logic to?

COMMISSIONER DOUGLAS: You know, I guess, the ones that -- well, two things. One, I'm agreeing with Tricia that maybe the rule should never go into effect. The data is essential for evaluating whether CMS understands truly the consequences. So one is collect the data. Then determine if the rule should go forward.

The ones that give me the most pause are the provider tax and the supplemental payment. There are some others that are more technical in nature that we've said that we have agreed -- or proposed in the past that are in alignment. So they could -- you could break it apart, but given it is one rule right now, I think it's hard to --

COMMISSIONER LAMPKIN: What I'm trying to get at is making sure that we have a balanced response to this

because a fair amount of what I see in here too is in response to our recommendations and our call for transparency about what providers are being paid here.

So I do think it's important for us to say, "Yay, CMS," to the extent that the parts of this rule emphasize our recommendations and shed some additional light and transparency into provider payments. So there's a "yay" part of our response, in my opinion.

There may well be concerns about access and valid things to say about delaying other parts of the -- certain parts of the rule until the data comes in and gets analyzed. I'm not arguing with that. I just want to make sure that there's some balance in the response that we make.

Then specifically on the recommendation that we had made in light of the findings last year with respect to -- so even when you do have a demonstration, you're not linking it to anything. I don't know that we would necessarily want to delay. We might still recommend or reinforce our recommendation from that time that you're collecting this data for a reason. Use it. If that UPL is an upper limit, link it to expenditure and see what's going

on there. I think we could reemphasize that as well.

CHAIR BELLA: Fred?

COMMISSIONER CERISE: Yeah, I agree with a lot of your comments, Stacey, on kind of the balanced approach to comments here.

Just to be specific, Rob, because you asked some of these questions, I do think saying "good job" on let's get provider-level data, add managed care into that as well. Make it publicly available.

But then I would -- sort of to the -- consistent with some of the other comments, I'd ask for -- can we get more specific about what the impact of this would be? I mean, you commented just on the provider tax piece, $34 billion. If half of those arrangements were to go away, I think that's what was in the tax there.

We know that there are arrangements that CMS has in mind here, and so can we just be clear about what those are, what the expected impacts would be?

We as a group have been critical of some of these financing arrangements and how it kind of distorts policy, and so I don't want to be too negative on it. But you pointed out we have very little on the directed payments

already, which is something that has been a stated goal there, and so let's get some clarity around what the goals are, what's those outcomes, how we measure that, and kind of plea for a balanced response here.

CHAIR BELLA: Darin and then Chuck.

COMMISSIONER GORDON: Yeah. I just want to align myself with Toby's comments, amended in a friendly way by Stacey, which I think is accurate. I think it's getting to the same point.

You need to see the information. We've all been saying that for some time. There's a whole host of assumptions that are being made as if these are all uniform and done the same way in each state and serve -- the comment that they don't really -- they may not serve overall objectives, I think there's some assumptions there. So, ideally, you have the information for which to really gage whether or not that's truly the case. So I do think those comments are helpful.

Also, I am a little concerned about the assumption that 50 percent of the states -- 50 percent of the spending will be made up for in base payments. I have no clue what they base that on, and I personally, as a

person who ran state, don't know if that would be remotely even an option in our state and some other states.

Again, I think if we get the data, have the information, understand really how some of these things are set up, because I do know that we have, in fact, seen some that do have expectations or requirements that do promote and lend themselves to greater access for Medicaid beneficiaries, and to Toby's point, it would clearly have some significant impacts in certain markets.

CHAIR BELLA: Chuck?

VICE CHAIR MILLIGAN: I think this has been a good discussion. There's three points I wanted to make.

I think in terms of the kind of complementary part of what we would comment on, I do think that we need to note that we have a responsibility about fiscal stewardship. This aligns with fiscal stewardship, not just transparency, not just some of how they're following our recommendations about provider-level data. But I think it's important for us to always confirm our commitment to fiscal stewardship and, of course, balanced with the access and the rest of it too.

The second comment I wanted to make is I think we

need to note the administrative burden piece of this, and I think that in terms of the proposed reg, CMS understates the likely actual administrative burden of compliance. So I do think that we have to just caution that the administrative burden is somewhat unknown and likely to be material in some form or other.

The third -- and this is actually something I would not suggest including. I'm going to be very explicit. I would not put this in a comment letter. But I think we've talked about as a Commission, and within D.C., the discussion keeps coming back to kind of like major financing reform -- per capita caps, block grants, and the like. I do think that without getting to that kind of specific comment, I think it's important for us to have a better understanding of just baseline spend and where it goes in the states to have a meaningful discussion the next time -- per capita caps and block grants and the like come around.

I do think that having provider-level data and more data will help have a meaningful discussion around the design implications of those kinds of major federal reforms.

So, without getting that specific but maybe intimating that the better we can improve our understanding of baseline spend, the better it will be to inform federal policy going forward, I think that kind of thing would be helpful.

CHAIR BELLA: I have a few comments, but I want to see if I've missed any Commissioners.

[No response.]

CHAIR BELLA: Okay. So I'm going to kind of say back to you all what I think I'm hearing, starting with just a couple of my own reflections.

So, first, on your question of technical comments, to the extent that we've done prior work and we can try to help inform the agency, we certainly should include some of that in our response.

Second, I agree with Chuck's point on stewardship. I want us to be equally strong on access, and in particular, we haven't talked much about -- but this is -- the relationship between access monitoring and the agency wanting to rescind those requirements and this rule, I would like us to at least note that there is a relationship there, and there does seem to be some

inconsistency in what we're looking at there.

If I recall, part of what they talked about in access monitoring also had to do with administrative burden, and so understanding is that a reason for pulling that over here and then why are we thinking administrative burden is any less or different over here, there just seems to be inconsistency. And there is a relationship between the two and particularly also looking at access for any reduction in provider payments, going back to the common theme of just we need more data before we can really make a statement on whether that has a negative or positive or no impact at all.

So I think, though, what I'm hearing from folks is, one, make sure we have a balanced response. Identify the areas that are consistent with our prior recommendations, but also make sure that we talk about lack of data. And along that being it seems that there is support for suggesting that doing some of this should be delayed until we have more of that data. I don't think we have to put a time limit around that. I don't think I've heard any of you suggesting a particular time limit.

But those are kind of the key themes that I hear

you all saying. Is there anything else that folks on a common sort of core theme or any questions, Rob or Moira, you have of us in terms of thinking about your response?

MS. FORBES: I mean, one thing just to point out is that our prior recommendations around getting provider-level data have been that data be reported at provider level and be made accessible. This involves collecting a lot of data, but it doesn't actually say anything about making it accessible.

So while a lot of the discussions here has been like, well, let's look at the data, I mean, we've gotten our hands on a little bit of -- like the UPL demonstrations because they kindly shared them with us, but like we have no view into the provider tax demonstrations or anything like that because those are not available now. And there's nothing in this rule that suggests that -- you know, as Rob's charts show, they are not going to be in T-MSIS or anything like that. So we don't -- that's just something to think about in terms of comments as well.

CHAIR BELLA: On that, Tricia?

Did you want to comment on that, Chuck?

VICE CHAIR MILLIGAN: Not about that.

CHAIR BELLA: Spoon feed us more. What are you asking for us? Are you asking for guidance on whether we need -- if we're unclear on whether we think that data should be shared and usable? We should not be unclear on that.

I think what you're hearing is there's no point in collecting it if we don't have any ability to use it.

MS. FORBES: Exactly. The Commissioners have made a prior recommendation that the data should be collected and made publicly available.

CHAIR BELLA: Yes.

MS. FORBES: I assume you want to say, add that again, because that is not in here.

CHAIR BELLA: Yes. So what I'm hearing from the Commission is collect it and make it available so we can actually use it.

COMMISSIONER DOUGLAS: Which I think gets to Chuck's point. Then we would have a complete picture for any future --

CHAIR BELLA: Tricia?

COMMISSIONER BROOKS: Just very quickly, I just want to go back to the comment I made about at least

sending something to CMS now and saying push out the comment period.

I think a lot of groups, states, providers are all having a hard time getting their head around this and how they should be commenting. This is going to take a very -- it's a long timeline to get this in place.

So I don't see any harm in asking CMS now to extend the comments period at least and not waiting until we embed that in our comments.

CHAIR BELLA: My main question on that is, What new information do we think would be available that would help inform folks' comments if they had more time?

COMMISSIONER BROOKS: I don't know that new information would be available. I think states would need to do some of that fact finding. They might be able to come up with new information, but I can't say that definitively.

But this is a big complex rule that's been proposed over two holiday periods, and it seems to me that extending it a month or two months isn't really going to change the nature of things, other than giving people who really want to digest it and better understand the

implications, to the extent that they can, they get that time.

CHAIR BELLA: Comments on that, Toby?

COMMISSIONER DOUGLAS: Yeah. I get where you're coming from, but I don't think more time -- the point, at least for me, is that it's not clear how they're -- and maybe this gets to a friendly amendment on our comments, which is, one, that they need to collect the data, and two, they also need to give clear examples of how they are going to use the data. For example, what I was asking Rob about what would that mean, how would they respond on differentiations in a particular state that they see on the provider tax? Would that be permissible or impermissible, so that there's clarity?

But I don't know by extension because states don't know exactly what this rule means and how it's going to be interpreted. So I think the point is we need -- extension is really just delaying. I think it wouldn't be genuine, and a better approach is to respond quickly and state that it's -- you don't have enough data yet. You need to get the data, clearly define how you would be acting on the data, and then maybe your rule is needed.

EXECUTIVE DIRECTOR SCHWARTZ: Can I ask a clarifying question?

It's going to take a little bit of time for us just to even write this letter based on this conversation and you all to review that and make it clear. Especially given the time of year, it's conceivable that we would not have our comments ready until after the new year, and the close date is the 17th.

So are you suggesting that we send a separate letter now saying extend the comment period?

COMMISSIONER BROOKS: Yes.

I guess my question would be what's the harm in asking for extra time because I think it would be appreciated.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah. I guess I'm just skeptical about whether that by itself would be favorably received other than saying it's a complex rule. And it would take -- it's going to take a long time for people to understand what's in here.

CHAIR BELLA: Tom?

COMMISSIONER BARKER: I guess I would agree with Toby. It seems to me that the issue really is

implementation and not the deadline for the comment period.

I think that a lot of the data necessary to respond to the rule is available now, and so I would be inclined to not send a letter asking for a delay but rather weigh in more after the comment period closes, because it's going to take months.

I assume that their goal is to get this out before the administration ends, next November, before the election in November, but it probably won't be until -- assuming that Congress doesn't even block this rule, which I think there's a possibility it could happen, but I just think that it's going to take well into next year for them to finalize it. And it seems to me that that's really where the focus should be.

CHAIR BELLA: I am reluctant to set precedent by sending a letter asking the agency to -- I mean, whether we like the way they're doing it or not, this is their process. I'd rather that our association with this rule be subject to the content of the rule.

It doesn't mean that other organizations, particularly if we're worried about states -- then perhaps NAMD will reach out to the agency and suggest an extension

of time.

I think we'll proceed with commenting on the rule and leaving the time period as-is, but I appreciate, appreciate that, Tricia, very much.

I do want to ask for public comment, but the good Vice Chair to my left has some additional closing words.

VICE CHAIR MILLIGAN: No, I just had one quick -- I did want to echo what Melanie said about the access as a part of it, but I want to make sure that when we do the access, whatever we do in the comment letter about the access, we talk about -- we make sure to hit the comment Peter made, which is there's access at kind of a macro level, but then there's also access for specific populations for specific services disproportionately impacted or at risk.

So I don't want to lose the kind of targeting or segmentation access risk embedded in the 222 million piece. So I just want to make sure when we talk about access, we get at the macro issue, but also we get at the targeting issue.

CHAIR BELLA: There is opportunity now for public comment.

Please introduce yourself and your organization. Thank you.

PUBLIC COMMENT

* MS. COLLINS OFFNER: Thank you. My name is Molly Collins Offner, Director of Policy for the American Hospital Association.

We want to thank the Commissioners for their thoughtful discussion this morning regarding CMS's Medicaid proposed rule.

The AHA understands both MACPAC's and CMS's interest in increased transparency and oversight of public programs, but we believe this rule goes beyond increasing transparency. It potentially could jeopardize access to critical funding streams that have been put in place precisely because the Medicaid program has been chronically underfunded. We're concerned that the Medicaid program could face further erosion in funding.

We are carefully assessing the rule, its impact. We're working with our member hospitals, the state association, and other key stakeholders.

And we support the Commission's study on how this proposed rule could impact how states fund their programs

and a direct results, Medicaid beneficiaries' access to care and the number of individuals that could be served by the program.

Thank you.

CHAIR BELLA: Thank you.

Do we have others wishing to comment?

MS. DANIEL: Hi. I'm Hilary Daniel with the Children's Hospital Association.

We very much appreciate the thoughtful conversation and discussion that's happened.

We'd just like to note that we do support requesting an extension for the comment period. We've been in contact with our members and are looking to gather more state- and hospital-level information that can help to inform CMS going forward. So we would support an extension of the comment period.

Thank you.

CHAIR BELLA: Thank you.

MR. SCHNEIDER: Good morning. I'm Andy Schneider, a research professor at the Center for Children and Families at Georgetown University.

I want to endorse my colleague Tricia's

recommendations for the Commission to ask the agency to provide more time for comment.

In 1991 and 1992, I worked for the Congress, and I worked for a member who was involved in designing and enacting the statutory framework that we're all operating under now. There's been a lot of water over the dam since then, a lot of expectations in place, a lot of structures in place, and I don't think, despite the excellent work the staff have done here, that anybody in this room knows what the effect of this rule is going to be on those expectations and structures, which if you're representing children -- and Medicaid is the largest insurer for children -- you'd be a little concerned.

So my other point is, again, as a former congressional staffer, I wish I had had a resource like you're providing available at the time. We didn't. So we did the best we could with the resources available.

But now the Congress does, and if I'm in the Congress as a staffer, I'm going to say, "So what does this mean for my state? Let's go through it, IGTs, CPEs, provider taxes, UPL, and supplemental payments. What's my state's situation? What's their exposure? What's going to

happen?

Those questions are coming. I don't have to prompt them. Any reasonable state would ask, and you're a reasonable body to ask it of.

So if you think you can proceed based on the information you have now, then you should do so. I doubt it.

CHAIR BELLA: Thank you.

Other comments?

[No response.]

CHAIR BELLA: Any final words from the Commissioners?

[No response.]

CHAIR BELLA: All right. Toby?

[No response.]

CHAIR BELLA: Okay. Thank you all. We will take a short break and reconvene at 11:15.

* [Recess.]

CHAIR BELLA: All right. If everyone could take their seat, we're going to reconvene.

All right. We are not going to turn our attention to a review of the PERM findings, so Moira and

Martha are going to take us through the findings. Just as a reminder to the Commission, this is sort of a briefing. There is no proposed rule here. There is nothing for us to comment on per se. But to the extent that what we learn here informs future work or future actions by the agency, it's important for us to have a discussion about this particular subject.

I'll turn it over to you guys. Thank you.

2019 PAYMENT ERROR RATE MEASUREMENT (PERM) RESULTS: ANALYSIS AND IMPLICATIONS FOR MACPAC WORK

* MS. FORBES: Thanks, Melanie.

Last month, the Department of Health and Human Services released its annual Agency Financial Report, which includes the Medicaid and CHIP improper payment rate estimates for fiscal year 2019. This year's report is significant because these are the first Medicaid and CHIP estimates that incorporate errors based on eligibility since the implementation of major eligibility changes in 2014 as a result of the Affordable Care Act.

Many state and federal policymakers have been waiting for this estimate as there has been very little

information on the accuracy of eligibility determinations since CMS replaced the eligibility component of the payment error rate measurement, or PERM, program with a pilot approach between 2014 and 2018.

Most accounts of the PERM results you may have seen have focused on the eligibility component of the error rates, in part because they're new this year. But because we haven't discussed the PERM program in a while, we want to spend some time today providing a refresher on it as well as a broader look at the AFR.

I'll provide a little more explanation of what PERM measurement is, and I'll summarize the key findings from the AFR. Martha will then describe CMS' proposed corrective action plans to address the findings and the implications of the findings for Medicaid and CHIP before turning it back to you for discussion. And we're happy to answer any clarifying questions along the way.

PERM, or payment error rate measurement, has been used by CMS for over 10 years to measure and report an unbiased national improper payment rate for Medicaid and CHIP as required by statute. PERM uses a 17-state rotational approach to measure the 50 states and the

District of Columbia over a three-year period. While CMS measures each state once every three years, the national improper payment rates include findings from the most recent three years of measurement, so all the states are averaged into the three-year national rate.

Because it would be impossible to review the accuracy of every Medicaid and CHIP payment, obviously, CMS uses a statistically valid methodology to select samples of payments from each state and then extrapolates findings from these samples to estimate the improper payment rate for each state and from that to the national.

A review contractor reviews all claims in the fee-for-service managed care payment sample to determine if each state's payment decisions complied with applicable federal regulations and state policies, and then beginning with this last review cycle, another federal contractor also conducted eligibility reviews of beneficiaries associated with the sampled fee-for-service and managed care claims. The contractor assessed the states' application of federal rules and then the states' documented eligibility policies and procedures.

So a couple things about the PERM errors. It

counts a payment as an error if the payment or eligibility decision did not comply with policies and procedures. This means that improper payments include both expenditures that should not have occurred but also includes instances where there was insufficient or no documentation to support the payment or eligibility decision as proper.

In addition, both the absolute value of underpayments and overpayments are considered in the estimate. The improper payment rate is not a measure of fraud. Fraud is a criminal decision that requires investigation. This is just a measure of improper payments. And, finally, PERM cites as improper any amount of federal share that's incorrect even if the total computable amount is correct, so if someone was assigned to the wrong eligibility category that receives an enhanced federal match, the amount of match that's wrong is considered an improper payment.

So on to the specific PERM findings from this year's AFR. The national improper payment error rate for FY2019 is 14.9 percent for Medicaid and 15.83 percent for CHIP. Overall, and consistent with prior years, the majority of errors in both Medicaid and CHIP were in fee-

for-service, followed by eligibility, and then managed care. So PERM is looking at payments made by the state. That's the statutory requirement. And in managed care, the payments made by the state are the capitation payments to the MCO. So PERM is only looking at whether the capitation payments are made correctly. It's not looking at the provider payments made by MCOs, which is why the managed care payment error rates are usually very low. It's hard to make a mistake when you're just making monthly capitation payments.

This chart shows a breakdown of the errors in the FY2019 Medicaid improper payment rate. This was reported in the AFR. The majority were due to instances where information required for payment or eligibility determination was missing from the claim or state systems or where the state had not followed the appropriate process for enrolling providers or determining beneficiary eligibility.

A smaller proportion of improper payments were for beneficiaries determined to be ineligible or for providers not enrolled in Medicaid or payments that could not be verified during review. And there's a chunk there

that says proxy eligibility estimate. That represents the eligibility component for the 34 states that haven't yet been measured using the new PERM methodology.

As in the previous five years, the largest component of the Medicaid improper payment rate is errors due to state noncompliance with provider screening, enrollment, and national provider identifier requirements. Most eligibility errors were due to insufficient information to determine eligibility, primarily income or resource documentation. So that's situations both where verification wasn't conducted or where there was information that indicated that verification was started, but there wasn't documentation to validate that it was completed. It just wasn't in the record. These errors don't necessarily represent payments for ineligible individuals.

A smaller number of Medicaid eligibility errors were due to noncompliance with redetermination requirements or because the beneficiary was determined to be ineligible for the program or service provided.

Here's the table from the AFR for CHIP. As with Medicaid, a majority of errors in the CHIP improper payment

rate were due to instances where information required for payment or eligibility determination was missing or where the state had not followed appropriate processes.

The largest component of the CHIP fee-for-service improper payment rate was also due to state noncompliance with provider screening and enrollment requirements. As with Medicaid, this was the first year since 2014 that a full eligibility review was included in the CHIP improper payment rate. The proxy eligibility estimate used to represent the eligibility component for states not yet measured using the new PERM methodology contributed a large amount in the overall estimate of CHIP improper payments in that pie chart on the previous slide. Failure to conduct timely redeterminations accounted for a large share of errors among the states in this review cycle in CHIP in addition to insufficient information to determine eligibility.

Finally, many eligibility errors were due to claims where the beneficiary was ineligible for CHIP but was eligible for Medicaid due to income, but PERM counts errors in federal match or errors in program assignment as an improper payment.

Now I'll turn it over to Martha.

* MS. HEBERLEIN: Thank you. So HHS works with states to develop state-specific corrective action plans, providing technical assistance as well as monitoring and follow-up with states as they implement these plans. HHS also develops an agency-wide plan to reduce improper payments that focuses on the major causes of errors, and I'm going to discuss that plan now.

So specifically related to provider screening and enrollment, the agency provides ongoing guidance, education, and outreach to states on federal requirements to enroll Medicaid providers. In addition, the Medicaid provider enrollment compendium was updated in July of 2018 to assist states in applying the regulatory requirements of provider screening and enrollment. Additional updates are planned for fiscal year 2020.

HHS also conducted site visits during fiscal year 2019 to assess provider enrollment and compliance and provide technical assistance in states. Finally, the agency shares Medicare and Social Security Administration data to assist states in meeting screening and enrollment requirements. For example, the link to Medicare data would

allow a state to rely on a screening completed by Medicare instead of having to complete its own.

CMS also describes several approaches in the AFR to address errors related to documenting and completing eligibility verification processes, including conducting redeterminations. CMS has initiated audits in states, including California, Kentucky, Louisiana, and New York, that have been identified as having eligibility errors in prior reports from the Office of the Inspector General or state auditors. The agency also released guidance in June of 2019 clarifying the requirements for eligibility and enrollment processes with a specific focus on the Medicaid expansion population and areas that states should prioritize to ensure proper claiming.

Finally, CMS plans to issue a proposed rule this spring related to Medicaid and CHIP eligibility determination processes, including requirements related to recordkeeping, verification of eligibility, redeterminations, and addressing changes in circumstances.

So moving on to the implications, in 2010 Congress required state Medicaid programs to more uniformly screen and enroll all Medicaid fee-for-service providers

and suppliers beginning in 2011. These requirements were later extended to apply to Medicaid managed care providers by 2018.

State Medicaid agencies must verify that provider applicants meet all federal and state regulations, verify state licensure, and check federal databases to determine if providers have been excluded from participation.

For providers with higher risk, additional steps must be taken, including conducting background checks and collecting fingerprints. Both the government Accountability Office and the Inspector General have raised concerns about state failure to fully implement the provider screening and enrollment process as well as CMS oversight of these activities.

HHS issued regulations regarding Medicaid and CHIP provider screening and enrollment in March of 2011, and the agency has since issued several sets of subregulatory guidance and has also provided technical assistance to states. It is unclear why states have not fully complied with the statutory and regulatory requirements, although MACPAC's prior work in this area indicated that on-site reviews and background checks

required new resources and follow-up, which may be a contributing factor.

So shifting to eligibility, the determination process should ideally maximize the number of correct decisions while also minimizing the number of incorrect decisions. This can be challenging because state system and process design choices that seek to minimize the rate of one type of error can also affect the rate of the other type. So, for example, a request for an applicant to supply documentation can result in an eligible person being found ineligible if she fails to respond to the request. On the other hand, an approach that allows for self-attestation without verification can result in an ineligible person being found eligible.

Changes made by the Affordable Care Act to Medicaid and CHIP enrollment and renewal processes were intended to reduce the complexity and effort for both enrollees and program administrators and allow determinations of eligibility and ineligibility to be made more quickly, accurately, and with less expense. So the PERM results indicate that most errors are related to documenting and completing verification processes,

including conducting redeterminations, and these findings are similar to some of those reported by the Inspector General.

For example, in some of the audits the state did not follow written policies and procedures when making eligibility determinations, and in others there were system, procedural, or human errors.

So, overall, the PERM findings suggest that there are opportunities to reduce the rate of improper payments by focusing on state systems and processes. Additional information on why states are not following the requirements related to provider screening and conducting and maintaining eligibility verifications may help inform the response.

For example, the response may be different if states are not maintaining sufficient documentation that a verification was conducted compared to if states are not conducting the verification at all. So, in light of these results, there may be areas that the Commission wants to further explore. In addition, the proposed eligibility rule will also provide the Commission an opportunity to comment.

So, with that, I will turn it back to you for questions and discussion.

CHAIR BELLA: Thank you very much. Kit?

COMMISSIONER GORTON: So thanks for bringing this back to refresh us and remind us as we head into what I think will be an interesting public discussion about these findings, and I in particular appreciate the balance you've made in terms of the difficulty of how commonly understood words have in the context of PERM been redefined as terms of art. And I have been uncomfortable since the beginning with calling these things "errors," but, okay, that's what they're called in this particular context. I think it's important, and I really appreciate the emphasis that just because there's one of these "errors" does not mean in any way, shape, or form that there's fraud happening on the basis of a beneficiary who's trying to pass themselves as eligible when they're not or a provider who's trying to bill for a service that they didn't provide or a managed care plan that's accepting capitation that they shouldn't be accepting.

If you operationally get under the hood and start to address these reports, what you find is what you very

importantly highlighted, which is it's often either very complex policies and procedures which are hard to operationalize and which people have a hard time coming to a common understanding about. There's a huge administrative burden, and yet people need to be determined eligible; they need to receive care in a timely way. Providers need to be paid for that care in a timely way, and the health plans and the fee-for-service programs need to do that.

It gets screwed up a fair amount, and that's not bad intent on the vast majority of people's part. It's just simply a very, very complicated thing to do right. And when you go in and start digging under, you know, what it takes to code, you know, eligibility categories so that you claim the right level of FFP for each and every person, that's just enormously complex.

And so I guess I would say three things. One, I'm glad you brought it up now, and I do think there may be a role for the Commission, whether it's with an information sheet or just some kind of summary that we would -- a resource that we could provide to help people to understand these things in the right context. And so to the extent

that we can contribute to that, I think we should think about doing that.

Two, I think it's very important that people understand -- we push for oversight and accountability. PERM is an oversight and accountability exercise, and when you take a complex process and subject it to oversight and accountability, what you find is stuff is broken, and you need to go in.

So the purpose of the exercise is not a game of whack-a-mole to go looking after beneficiaries or providers or other bad actors. It's in this complex ecosystem that we've created in terms of financing health care for low-income people and people with disabilities, how do we improve continuously over time our accuracy in doing it? And so I think that's enormously important. And I thought I had a third thing, but I'm just going to shut up. So thank you.

CHAIR BELLA: Reserve the right for your third. Brian, then Darin.

COMMISSIONER BURWELL: So I have a question about the large percentage of errors associated with noncompliance with provider enrollment. Does the report

itself provide detailed information about where the areas of noncompliance are? Is it failure to do background checks, financial reviews, incomplete applications? Is there detailed information available? And I have a second question.

MS. FORBES: No. This is the HHS agency financial report, and there was -- actually, they provided an appendix, which was nice, that had these pie charts and the CMS corrective action plans, but CMS has not released any more detailed PERM findings yet. So they may have a more detailed breakdown at some point, but this is sort of --

COMMISSIONER BURWELL: So will that data be accessible? We don't know exactly where the areas of noncompliance are in terms of providers at all?

MS. FORBES: We don't know a whole lot more than this, no.

COMMISSIONER BURWELL: And in computing, in estimating the amount of money lost due to provider noncompliance, once a provider is identified as being improperly enrolled, do all payments made to that provider over the course of the year be considered errors?

MS. FORBES: No. PERM extrapolates from the sampled claim, just from the sampled payment.

COMMISSIONER BURWELL: Just from one claim?

MS. FORBES: Yeah.

COMMISSIONER BURWELL: Okay.

CHAIR BELLA: Darin.

COMMISSIONER GORDON: I agree with a lot that Kit had to say. This is a tool, and I don't think you dismiss the tool because it does identify areas where agencies could tighten up their processes, because it is a complicated program and, you know, we talk about the importance of transparency on data to understand how things are going. Well, here's your transparency on, you know, some of the things they're looking at.

I wouldn't want that comment to be taken as that this process is perfect by any means because I've seen it on the ground where you have people who have their day jobs that have to work with the folks doing the reviews. And there were situations where they just missed the timeline, you know, to get them back the information and, therefore, it was an error, which obviously then -- you know, whether or not it's right, a great level of precision, I don't

know. Is it directionally right? Probably, that there are some things that can be done within the agencies to tighten up their processes. It is, in fact, a tool.

The other thing I have seen with this is that sometimes -- and, again, to Kit's point -- there's an expectation that certain things will be done or provided on a claim, you know, or a certain documentation. It takes a while to move a Medicaid program to get every provider in the state doing that. In our small state -- I couldn't even imagine how many Toby had in California -- we had 60,000 providers. And, you know, depending on when you find out that that's the new expectation or requirement and then you can push that information out and educate providers, that takes time to move the system.

So, again, I think it is a good tool. I do think there's some aspects from a process perspective that -- I wouldn't say that every endpoint from a number of perspectives for a state is 100 percent spot-on that there is, in fact, a true error there versus, you know, manpower constraints or the time frame in which they had to get compliance throughout the system. But I don't want us to get to the point where we don't think that PERM adds value

because I think it does.

CHAIR BELLA: Bill?

COMMISSIONER SCANLON: Yeah. I have a question and then a comment, and actually, the comment is very similar to what Darin and Kit have been talking about. In part, it's to reinforce what you were saying in terms of what we have here.

This is not about fraud; this is about sort of inappropriate or inaccurate payment. And that is a much bigger universe than any potential sort of fraud that exists.

Having said that, I think we have to think about -- even that breakdown in those pie charts isn't enough to tell us what we need to do in terms of thinking about how do we reduce the sort of amount of inappropriate payment.

They’re mistakes, I mean, they reflect mistakes on multiple parts. They could be beneficiaries. They could be providers. They could be the program administrators, and I'll even put onto the table, they could be the auditors that were reviewing these claims. All of those need to be thought about in terms of identifying what is an appropriate response to try and make

things better for the future.

As you said, CMS has not shared any of that further detail. Hopefully, they are actually doing something in that regard.

At the same time, I'm going to acknowledge, formerly from GAO, we regarded sort of Medicare and Medicaid as high-risk programs, high risk permanently in some respects, because they are necessarily complicated.

If you think about it, you've got over 100 million beneficiaries and over a million providers sending in claims, and you're supposed to pay them appropriately. If you don't set a lot of relatively detailed specifications for how and what you're going to pay for, you would be accused of, really, misuse of public funds. So, therefore, the rules are going to be complicated, but having complicated rules creates a burden that we try to make them as clear as possible and make sure that we're complying with them as much as possible.

Again, I think this has been very useful, and I think it's important that we -- in this discussion, we've been right on target in terms of how we should interpret what the findings are.

Now, here's my question, which is about the findings, and it's Slide 5. There's a very substantial difference between the rate for -- it's that one, right. There's a very substantial difference in error rates between managed care and fee-for-service, and my question is I understand fee-for-service. It's largely sort of the claims that are coming on for individual services. What I'd like to know is sort of how do we measure managed care error, and are we talking about here a comparison of apples and apples or apples and oranges?

MS. FORBES: Someone once said in a PERM meeting, it's apples and fish.

[Laughter.]

MS. FORBES: No, very different. Very different, because it's just looking at the state -- the monthly capitation payments, which are largely automated and subject to very simple payment rules in most states as opposed to sort of daily complicated -- or not daily, but fee-for-service payments that could be for any type of service from multiple kinds of providers and coming in and being adjudicated under all those payment rules to the MMIS. They are being paid by different systems under

different rules.

So you'll see if we get the state-level PERM results from CMS, states that have a high proportion of managed care can have a lower error rate, just because of the nature of their payment systems.

CHAIR BELLA: Peter, then Tricia.

COMMISSIONER SZILAGYI: Sure. A comment and two questions.

The comment is I want to add my voice to the chorus that Kit started and a plea that these data not be misinterpreted that patients are taking advantage of the system to a large extent or that providers are taking advantage of the system to a large extent. That's not what these data show.

The two questions, is the process or the steps that states or providers need to do the same across the states? I mean, we have a natural experiment with 50 states here. Are those processes the same, and are some states doing better than others? And can we learn why the error rate may be lower in some states? You may not have that data. Maybe CMS does, but one of the neat things about Medicaid is that we can learn from variations in what

happens across the country and best practices across states, or is most of this due to resource or other things?

MS. FORBES: Are you talking about the provider enrollment? So all states are required to comply with the same provider enrollment requirements.

The GAO just released a study in November where they did go look at seven states to try and understand better what the differences were and how states were able to comply with that. Honestly, all the states are struggling still, although there are differences -- and came back with it's a variety of resources. I mean, it's often resources and systems, you know, manpower resources, technical resources. It's all of the challenges.

It partly depends on -- the requirements for screening providers of managed care are newer, and so, on the flip side, states that have a high proportion of managed care providers suddenly had to enroll all of those providers more recently, and so they have a new resource problem. I mean, there's a lot of differences among states in how they've been affected by the rule as well.

So there's been some research into that, and CMS, as Martha said, in its correction action has been trying to

provide some technical assistance to the states, partly by identifying some of those practices and sharing them.

CHAIR BELLA: Peter, did you have another question? I thought you had two.

COMMISSIONER SCANLON: [Speaking off microphone.]

CHAIR BELLA: Okay. Tricia?

COMMISSIONER BROOKS: So just three quick comments. One, echoing the issue of beneficiary fraud and the fact that there's really no evidence of that, but certainly Medicaid critics are jumping to the conclusion that when you say an eligibility error that there was intent on someone's part to commit fraud.

I would love to see MACPAC try to dig into the issue of beneficiary fraud so we can go on record with some real evidence of the fact that it is minimal or negligible, whatever that ends up being.

The second point I want to make is when you look at the percentage in the pie charts that were determined to be ineligible, you see 3 percent of Medicaid, 11 percent in CHIP, and many of those in CHIP were because they belonged in Medicaid, not because they were ineligible.

But I want to point out that PERM does not

evaluate negative cases. It does not look at those that were denied to say it's an error to deny this person who actually was eligible. Now, that actually gets swept into the -- in between cycles on the quality work that gets done, but PERM and the error rate doesn't include that.

The third point is I am extremely hopeful, although I don't normally hope for regs to come out quicker, but for the eligibility rule, it would be great if it does come out sooner and we have evidence -- or some sense that it will, so that MACPAC can take a harder look at that, because my sense is that it's going to -- and everyone's sense is it's going to tighten up the rules, and it's going to impose more red tape. And what's going to happen is that's actually going to make things worse, that we really need to focus on making things work now based on the rules that are in effect. And then we can look at what more needs to be done.

But I do think that things are going to get worse before they get better as a result of what happens with that eligibility rule.

CHAIR BELLA: I just have a clarifying question. Given that this is -- I mean, this is the first time

they've done it with eligibility changes under the ACA, and they have a new contractor doing it. Is the process they're using now comparable to what they've done in the past? So we could look at trends and understand how much of this -- like is the provider piece growing or shrinking? It seems very large, right? And it has not been the focus.

The focus has been on eligibility piece, and I don't know if the focus has been on eligibility because there's been so much pent-up interest in this coming out because we haven't had it for several years, but can we look at trends over time? And are we seeing major differences?

MS. FORBES: So the fee-for-service and managed care components are comparable and can be looked at over time.

The eligibility piece is new. They have not -- I mean, both in being -- there was a new rule a couple years ago that the Commission commented on, and so the rules were changed. The method of doing it with a contractor doing it was changed, and obviously, the underlying systems that are being measured have changed.

So the PERM results prior to 2014, which were the

last ones we have, can't really be compared to the numbers now.

CHAIR BELLA: This last question in terms of -- what does Medicare do to look at the provider piece?

MS. FORBES: So Medicare has what is called a Comprehensive Error Rate Testing program, or CERT, and it showed similar results in terms of -- the majority of the errors, I believe, are also due to failure to properly screen providers.

I mean, I might -- I'll need to go back and check that, but it's been a problem for them as well.

CHAIR BELLA: You would think that Medicaid and Medicare could somewhat leverage the processes they're doing to make sure that everything is on the up and up with the providers.

MS. FORBES: And they do share data. States can rely on a Medicare finding, and there is a process where states can send their provider file to CMS. And CMS will match it up against the Medicare provider screen and send it back, and states have found that between like 40 to 70 percent of their providers may match. And a lot of states are doing that now at least for the redetermination, the

reenrollment they have to do every five years. It takes a lot of the work out.

CHAIR BELLA: I was hoping you were going to say Medicare was at a zero, so we know if we use their stuff that Medicaid would be better.

Brian?

COMMISSIONER BURWELL: Is there anything in your review of this issue from not only CMS's report, but GAO that points to provider types that are more likely to have noncompliance, like personal care providers versus doctors or those kinds of things? Because there's a lot of --

MS. FORBES: So there are three tiers. There's low risk, medium risk, and high risk, and the medium risk require a site visit, and the high risk require a state visit, and the high risk require fingerprint and background check.

And so some states have to have authority to do -- like the state itself has to have the authority to request the fingerprints and to do the background check, and so there's been a process at the state level to get the authority to do that. So that's resulted in a delay in some states, and also some providers -- there's been like

pushback in some provider communities, so the types of providers that are considered high risk in the rule, and they're subject to that.

I don't know if that's the source of the problem, but the GAO, in talking to some of the states, found that the high-risk types of providers and some of the medium-risk types of providers are just more difficult to screen.

Also, the states have found that obviously the level of effort involved in doing the site visits is obviously much more significant than the types of work that Medicaid agencies had done formerly in terms of enrolling providers, and so it took a while to do the staff, you know, sort of staff up for that level of effort, so, again, the provider types that fall into that medium-risk group.

I mean, most physicians are in the low risk. It tends to be certain types of facilities and certain types of -- like home health and DME are considered high risk, for example.

So it's not the majority of providers that fall into those higher groups, but they are more difficult to get through the process. And, therefore, it's just -- you know, one assumes that, therefore, probably more likely to

be incomplete.

CHAIR BELLA: Chuck?

VICE CHAIR MILLIGAN: I wanted to thank you guys for this work. I think it's really helpful, and the way you've kind of characterized it and explained it has been very helpful.

One comment I wanted to make, it follows up on Bill and Peter, a little bit of what you said.

I just want to give an example of why there are variations across states and how the complexity itself can produce inadvertent errors or inadvertent issues.

One of the examples is I'm aware of a state where certain -- family practice docs within their scope of practice are allowed to prescribe certain kinds of psychiatric medicines, but within the Medicaid payment policy in that state, that has to be referred instead to a psychiatrist for managing the complexity of the mental illness underneath the need for that particular drug.

So scope of practice permits it, but the state Medicaid policy doesn't want that family practice doc to prescribe that particular psychotropic.

As states are complying with some of the provider

coding issues and taxonomy issues and category of service issues, all of those rules can produce errors if that claim is paid, the pharmacy claim is paid, that the family practice doc prescribed, even though it's kind of a violation of Medicaid payment policy, because the state wants a psychiatrist to manage that case. And that isn't true in other states.

So when you get to that level of granularity of Medicaid payment principles, Medicaid payment policy, and trying to achieve policy objectives, it can produce payment errors where the individual needs the medication, but just kind of how it was prescribed was there was an error. And so it's that kind of complexity state to state, issue to issue, and the complexity can produce errors.

We're talking about Medicaid and CHIP. It's very -- I think if people were to look at just error rates on tax returns, not fraud, error rates just with the complexity of the Tax Code, anything like that, it would be the same kind of outcomes, I would suspect.

My comment -- well, while we're on this slide, I just wanted to -- this slide and Slide 8, should it be labeled the dollar values on each of these slices are in

millions? Is that correct? I just want to make sure before we push this up on the website and before anybody out in the audience might be taking notes.

MS. HEBERLEIN: Yes. In millions. Sorry.

VICE CHAIR MILLIGAN: That we're not talking about $17,000.

MS. HEBERLEIN: No.

VICE CHAIR MILLIGAN: All right.

MS. HEBERLEIN: That would be a much smaller error.

VICE CHAIR MILLIGAN: Yeah.

So I hesitate to point that out in public, but if anybody is taking notes, I just want to make sure that our labeling is okay when we put this up online.

MS. HEBERLEIN: Now it's in the transcript.

VICE CHAIR MILLIGAN: And now it's in the transcript. Thank you.

The comment I want to make is I think we've seen in a lot of industries and areas that the more you encourage kind of an openness to the process, you get better quality improvement over time. I think we've seen that with how peer review is done among doctors to like

open up their cases to each other. We've seen that with aviation safety, all of those kinds of examples where -- so I would want to just state for MACPAC that the more that we can socialize kind of a culture around PERM that is it's good to understand these issues, to fix them going forward, and it's not a punitive process, it's not a recoupment process, I think that will lend itself better to actually reducing the error rate over time instead of like encouraging behavior that hides things.

I'll end there.

CHAIR BELLA: Other comments?

Sorry. I do think where you all are hearing an interest in having us be able to put together some sort of -- I think you called it an "information sheet," Kit, or some sort of resource, maybe a one-pager or something, I mean a couple of – that the focus in the media certainly has been around eligibility, and at least even getting the message out, as you've said, the largest share of errors is on the provider side. Again, not to point fingers here, but just to provide a balanced view.

Also, I think the point needs to be understood that if managed care was included in here, the percent

error rate would probably be quite a bit -- maybe not quite a bit less, but it would be less, right, like we're missing a large chunk of -- I don't know if we are or are not, but the fact that managed care is not in here would lead one to believe that this rate might be a little over-inflated when you're looking at percent of total cost.

We don't have to speculate on that.

MS. FORBES: I'm sorry? Managed care is in here.

CHAIR BELLA: Not managed care from the plans to the providers, the way Medicaid from the state to the fee-for-service provider.

MS. FORBES: Yes.

CHAIR BELLA: So I don't think it's so simple to necessarily get the capitated rate from the state to the plan, but I'm certain that -- point being, I think it's important that people understand what's happening at the managed care level versus the fee-for-service level, just as we try to provide insight into folks who don't have time to read the whole report and who may have just caught a few headlines recently.

We could leave it to you all to decide what that appropriate sort of resource is.

I think we'll take comments from the public now.

PUBLIC COMMENT

* MR. SCHNEIDER: Hi. I'm Andy Schneider, and I'm a research professor at the Center for Children and Families at Georgetown, and I'm commenting now in my personal capacity, having spent some time working on program integrity at CMS a couple of years ago on the provider screening and enrollment.

I just want to endorse Bill's question about the difference in error rates between managed care and fee-for-service.

The provider screening and enrollment rules have a very simple person: Keep out bad actors. It's extremely important, as I don't have to tell you, that the program be perceived as not being overrun by bad actors. There are all sorts of administrative and logistical and other issues around that, but it needs to be done. There has to be an understanding on everybody's part that we're trying to keep bad actors out.

We have no idea what's going on, on the managed care side, because PERM isn't looking for it. It's not asking the question, which is sort of unfortunate since

most of the lives in the program are in managed care. Do we have bad actors in there or not? Are federal dollars just flowing through to the bad actors?

I just think it's a fair question. The agency is not asking it. You should consider whether you should ask the agency to start drilling down because it's a fundamental program integrity matter.

Thank you.

CHAIR BELLA: Any additional comments from the public?

[No response.]

CHAIR BELLA: Any additional comments by Commissioners?

[No response.]

CHAIR BELLA: All right. Thank you very much.

We are adjourned until -- we'll be back at 1:15. Thank you.

[Whereupon, at 11:57 a.m., the meeting was recessed, to reconvene this same day at 1:15 p.m.]

AFTERNOON SESSION

[1:13 p.m.]

VICE CHAIR MILLIGAN: So we're going to get started.

Chris and Amy, I'm going to be kind of shepherding this particular session through. Know that there's been a lot of interest in a lot of high-cost drugs, and we recently convened an expert roundtable and looking forward to what you learned and what the findings were coming out of that process.

So the ball is in your court.

THEMES FROM EXPERT ROUNDTABLE ON MEDICAID POLICY ON HIGH-COST DRUGS

* MS. ZETTLE: Great. Thank you.

So today Chris and I are going to be sharing some themes from a recent expert roundtable that MACPAC hosted in November on high-cost specialty drugs.

We convene these roundtables from time to time to hear from experts with different backgrounds and perspectives, and the discussion can help us better understand complex policy issues and explore potential policy options.

So before I provide a little bit more detail on the actual roundtable, I'm first going to provide some background on the Medicaid Drug Rebate Program and high-cost specialty drugs.

We'll then walk through the key themes from the roundtable. I'll focus on some of the challenges that came up during the discussion, and Chris will walk through the potential policy options and next steps.

So just as a brief reminder, the Medicaid Drug Rebate Program requires that all participating drug makers pay mandatory rebates for all outpatient drugs. In turn, states must essentially cover all medically necessary drugs.

Statutory rebates ensure that Medicaid receives the best private market net price, and that these net prices do not increase faster than inflation.

On top of these statutory rebates, almost all states use supplemental rebates to lowering drug prices. States negotiate directly with drug makers to extract supplemental rebates, and this is often done in exchange for more favorable coverage positions.

The Commission has made recommendations on the

Medicaid Drug Rebate Program in the past. These recommendations would improve operations, increase rebates, and provide states with some additional coverage flexibilities.

Now, while these recommendations didn't specifically address specialty drugs, the Commission's ongoing work really brought this issue to focus.

We heard on previous panels from states and drug payment experts that the current tools are not sufficient to address the unique challenges that specialty drugs bring.

So now for a little bit of background on specialty drugs. First, there's no consistent or uniform definition for specialty drugs. However, these drugs do have some unique attributes. I'll walk through some of them now.

So many of these specialty drugs do have and require complex manufacturing and handling requirements, and they often lack clinical alternatives. Some of these drugs have high up-front costs. So, for example, gene therapies which modify or replace a gene to treat or potentially cure a disease, these one-time treatments have

potentially long-term or durable effects, and as a result, the cost is typically high up front since the drug makers don't receive continued revenue from ongoing treatment.

A recently approved drug, Zolgensma, was approved to treat children with spinal muscular atrophy, and it's been found to make significant improvements in children's motor functions. This one-time treatment has an up-front cost of $2.1 million.

Also, many of these drugs are administered in a medical setting, so hospital outpatient settings and physicians' offices. These drugs can include injection and fused drugs and oral cancer drugs.

Some specialty drugs have less clinical evidence. So, for example, the FDA has an approval process an accelerated approval process, which sets a lower evidence threshold than for traditional pathways. So the FDA can approve a drug based on its ability to likely have a clinical benefit.

For example, the FDA could approve a cancer drug for its ability to reduce the size of a tumor, assuming that that would then result in a clinical benefit.

As a condition for approval, these drug makers

are required to conduct post-approval studies.

So specialty drugs account for a growing share of Medicaid spending. Twelve out of the top 20 Medicaid drugs by spending are specialty drugs. These drugs are used to treat HIV/AIDS, hemophilia, cystic fibrosis, and hepatitis C.

A recent analysis done by Magellan, which is a large Medicaid pharmacy benefit manager, found that between 2017 and 2018, the cost of traditional drugs actually fell by 2.6 percent, but specialty drugs increased by 6.1 percent. We expect that this trend will continue.

Magellan also forecasts that specialty drugs will represent 50 percent of Medicaid spending by 2020.

The pipeline also includes cell and gene therapies. One study estimates that we'll see between 40 and 50 launches by 2030, with 12 launching in the next five years.

So our expert roundtable was held on November 6th and included federal and state officials, legal experts, drug payment experts, Medicaid managed care organizations, drug manufacturers, patient advocates, and providers. The roundtable sought to explore challenges related to

effectively managing specialty drugs. We reviewed current state models, and we explored a range of potential policy solutions to better manage spending.

So I'll now walk through some of the key themes that came out of the roundtable.

First, a reoccurring theme of the discussion was around the underlying challenge of very high list prices. So while mandatory rebates do result in a lower net price, some participants felt that this was insufficient for drugs that have very high list prices.

For example, participants talked about the challenge of paying for gene and cell therapies that have list prices ranging from $300,000 to $2.1 million.

States expressed concerns that even with rebates, this can have a significant impact on state budgets.

Now, there was broad agreement that drug prices should reflect the value of the drug, and that drug makers should receive a return on their investment, and that the system should continue to incentivize innovation.

Many participants shared that specialty drugs -- or shared concern that some specialty drugs are set at a monopoly price that is often not reflective of the drug's

value, and that these list prices can already account for any potential discount and rebates.

State officials raised concern of the lack of clinical evidence for a subset of specialty drugs. Participants focused on two examples, one, those accelerated approval drugs and, two, drugs that are approved with broader indications than what was studied in the clinical trial.

Some participants expressed strong concern about Medicaid covering drugs that do not have evidence of a clinical benefit. Furthermore, there was concern that some of these post-approval studies are not being conducted in a timely manner, and this is leaving states and payers with very little information.

Some participants wanted to ensure that Medicaid maintains coverage of these drugs, but they did share the concern that Medicaid is paying high prices for drugs that have not demonstrated value or clinical effectiveness.

So there was broad agreement that drugs with no competition can be the most challenging to manage. State officials shared that without the ability to exclude coverage, they often have little leverage to negotiate

supplemental rebates or even encourage drug makers to enter into more innovative payment models.

Representatives for drug companies noted that Medicaid does benefit from negotiations that occur in other markets where payers are able to exclude coverage.

Lastly, one of the key challenges that was discussed was around predicting drug spending and the potential tradeoffs that are required, given budget constraints. Some participants noted that states really have a hard time having clear insight into what the drug pipeline looks like and how it will affect the Medicaid program. This can also be a challenge for managed care organizations who are paid a capitated rate that may not always reflect the new costs associated with recently approved drugs.

Roundtable participants discussed sustainability challenges associated with specialty drugs for large populations but also talked about some of these rare disease drugs as they can create budget volatility and may affect states and MCOs differently, based on the patient populations.

It's worth noting that most states do have a

requirement to balance their budgets annually, and an increase in the number of high-cost drugs could result in tradeoffs for the states.

As part of this work, we did want to better understand how current alternative payment models are working in the states. These are still being implemented, but we wanted to get a sense from the participants, how they're working and if there are current limitations to these models.

First, these models do require significant staffing and resources to develop and implement. These models also tend to be limited to drugs where there is competition. So states shared that drug companies are more incentivized to enter into these alternative payment arrangements, where there are multiple drugs in a class and where they want to use the arrangement to increase utilization.

For outcomes based models specifically, there are some limitations based on the data available. So these contracts may be limited to what we see on claims, but information related to clinical effectiveness of a drug is often found in the medical record, which states are not

able to easily extract.

Finally, some participants noted that the ability to achieve significant savings from these models may be limited because, ultimately, drug makers can set a list price at a point that already would account for these potential rebates or discounts.

With that, I'll turn it over to Chris.

* MR. PARK: Thanks, Amy.

The roundtable participants discussed various policy options and strategies to address some of the challenges that Amy just presented. We have organized the discussion around particular discrete options. However, keep in mind that none of these options are mutually exclusive.

So, to start, as Amy mentioned, states have difficulty predicting what impact will be of drugs in the pipeline. The actual price of a new drug and the breadth of its indications are not available until a drug is approved by the FDA.

Moreover, the FDA may approve a drug faster than expected. For example, a recent sickle cell therapy was just approved by the FDA three months earlier than

expected.

The Commission's recommendation last June to create a 180-day grace period could help states prepare to cover these drugs. In addition, participants discussed ways for CMS to disseminate more information to states about drugs in the pipeline; for example, providing information about the potential population size that would be affected by the drugs and providing guidance on what types of payments or rebate arrangements may be accepted.

There was also some discussion about using different rebates to create incentives for manufacturers. For example, for accelerated approval drugs, where there is less clinical evidence, rebates could be raised until the point where they submit the post-approval study, demonstrating the drug's clinical effectiveness, and then they could be lowered back to the normal amount.

Participants did discuss one of the challenges might be that the manufacturers would just build the additional rebates into the list price.

Another way the rebate formulas could be changed is that you could create a benchmark price, for example, a value-based price, where if a manufacturer set the price

below that benchmark, then the statutory rebates could be lowered.

One challenge with that option would be determining what the benchmark price should be and how quickly you could establish that benchmark price.

To help states with their budgetary concerns, the federal match could also be increased for certain high-cost specialty drugs, such as treatments that are durable or potentially curable. Although increased match would help insulate states' concerns with their budget, this would just shift spending to the federal government, and so this option would likely need to be paired with some way to lower overall spending for a drug.

Participants also discussed the concept of a closed formulary. There are some concerns of a closed formulary affecting access, and so to try to reduce those concerns, participants suggested that the ability to exclude coverage of a drug could be more targeted. For example, they pointed out combination therapies, and that these drugs potentially be excluded since the individual components of the drugs may already be covered.

Another suggestion was to change medical

necessity requirements so that states would have more flexibility in coverage, particularly for drugs where there is a lack of strong clinical evidence; for example, the accelerated approval drugs or where drugs have been approved for indications that are broader than what was studied in the clinical trial.

Another option discussed was paying over time, such as paying for a particular drug's cost over five years, like a mortgage. This is different than the existing subscription models that a couple of states have put into place, where payment is made up front, but once they meet certain spending thresholds, subsequent prescriptions are essentially free.

Paying over time could be useful to help make spending more manageable and predictable; however, state officials had some concerns with this option. First, they questioned if states would be able to access federal match in the out-years of a beneficiary is no longer enrolled. Second, such arrangements could conflict with existing state contracting requirements and prohibitions against borrowing; and finally, some arrangements would create substantial obligations for future state budgets, reducing

the states' flexibilities in the future to address specific needs.

Another reoccurring and underlying theme was the lack of a link between value and price and the need for some entity to make an assessment on a drug's value. A value-based price could be used in rebate negotiations or used to establish the market price. Presumably, this value-based price would apply to all payers, not just Medicaid. Some participants mentioned that even a value-based price could be considered to be too expensive, and others had concerns that price setting in this manner may not provide manufacturers with an appropriate return or could reduce incentives for future innovation.

Some participants discussed a national-level risk pool to help spread the risk across all the states. Under this model, states would pay into the pool to purchase certain high-cost drugs. The risk-pool would allow states to spread risk across more beneficiaries and make spending more predictable.

Several participants suggested that this risk pool could also be extended to cover all payers. An all-payer pool would create better distribution of cost across

all lives and could help alleviate the concern that one plan or payer is paying for the drug, but the long-term benefits accrue to another.

One of the limitations to the risk pool is that it does not really change the cost of the drug nor address the overall growth in spending.

Although all these policy options that I just described could be applied broadly to all outpatient drugs, the options could be targeted specifically to a subset of drugs to address some of the unique characteristics of specialty drugs.

Participants discussed whether a subset of drugs should be carved out of the rebate program and covered under a new authority. Such a carve-out would allow policies to be specifically targeted without affecting the existing structure of the rebate program, which works well for most traditional products.

There was broad discussion on how to identify the drugs that might be carved out, such as gene therapies, or whether the carve-out should be targeted to certain conditions such as spinal muscular atrophy or hemophilia, where there could be different forms of high-cost drugs

used to treat the conditions.

So, with that, I'll conclude the presentation. Based on these policy issues and approaches that we just presented, we would appreciate your feedback on these topics. We'd appreciate any guidance you have on which policy options you're interested in and which to develop further, and for those options, what additional information would you need to help you move forward in your deliberations?

Thank you.

VICE CHAIR MILLIGAN: Thank you, Chris and Amy.

Commissioners? Darin, did you want to get us started?

COMMISSIONER GORDON: Thank you for this. It's very helpful.

One question about coming around medical necessity and needing flexibility there. Help unpack that for me because I feel states do have some ability to come up with their medical necessity guidelines. So I'm just trying to understand what you're thinking there.

MR. PARK: Sure. And some of it is medical necessity is not specifically defined, and so it's kind of

a gray area as to what states are allowed to do and what some other people might interpret as being medically necessary.

So I think there could be usefulness in kind of helping define certain cases that may be allowable as an exception to medical necessity, such as combination products. Like if the particular chemical entities are covered, then you don't necessarily need to cover all versions of that particular product. So that's, I think, where they're trying to get at some of the nuances in this kind of gray area of what medical necessity is. Yeah.

VICE CHAIR MILLIGAN: Are there other Commissioners who had questions or comments?

[No response.]

VICE CHAIR MILLIGAN: Chris and Amy, let me ask a couple of questions.

When you talked about the accelerated approval process, you did mention the requirement to do the evaluation. Are there any criteria, other criteria around how a manufacturer can get a particular drug into the accelerated approval process? In other words, what are the criteria by which a manufacturer or the FDA makes a

determination about whether it's appropriate for a particular drug to be subject to that accelerated approval criteria?

MS. ZETTLE: Yeah. Thank you for the question.

The FDA defines it as that the drugs would treat a serious condition and would fill an unmet medical need. So that that's sort of their definition, and it's at their discretion.

VICE CHAIR MILLIGAN: So kind of the gist of it, it sounds like, Amy, is we don't want the patients to have to wait for a protracted study period because if there's a chance that might help people who are in severe need with a very serious condition, let's try to -- so it's more to try to deliver it to market for the patients quicker because of the significance of the condition that the medication would treat. Is that fair?

MS. ZETTLE: Yes. That's our understanding.

VICE CHAIR MILLIGAN: Do we have a sense of the integrity of whether the drugs going through the accelerated approval process meet those criteria? Because it seems like some of what came out in the roundtable relates to how quickly some of these very expensive

medications come to market, in some ways, before they're fully proven, and I'm just wondering whether we have a sense of kind of just the -- whether the criteria are being applied in a way that seems to meet the intent. Do we have a sense of that?

MS. ZETTLE: Yeah, so a lot of the research that we have seen and I think the focus of the participants' conversation was more around sort of the requirement to do the follow-up studies, and there has been some, you know, analysis done on that. And I'm not familiar with any studies or conversations around sort of whether or not the FDA is appropriately applying that criteria. I don't know, Chris, if you have any --

MR. PARK: Yeah, I think the general sense of the participants is that, you know, they're going to trust that the FDA approved the drug appropriately, but in those cases I think they're a little bit concerned that -- one comment we kind of heard is in a way the payers are ultimately paying for the clinical trial for these manufacturers to prove effectiveness. And so they were a little bit concerned that a lot of these drugs have been high cost, and it's not necessarily been proven that they are

clinically effective or delivering the benefit that they're supposed to be at that price. And so I think they wanted ways to lower the cost but still provide access, and so one way may be to raise the rebates or somehow establish a price that is lower until they deliver those post-market studies to show the effectiveness.

EXECUTIVE DIRECTOR SCHWARTZ: And another point that particularly the state folks expressed was, you know, the manufacturers are coming in and saying some of these are one-time treatments or what they call "durable," but there’s some skepticism since we haven't had a long track record of knowing what that really means. How durable is durable? And, also, some of these drugs are being promoted as cures but people who are getting them still have intense amount of disability. It’s overpromise of what the drugs can do, but obviously for people who are facing very severe conditions.

VICE CHAIR MILLIGAN: A couple of other questions I had. One is I know we've talked about this topic in the past. There's been discussion about kind of we're at the tip of the iceberg stage. There's a lot of genomics work going on. There's a lot of gene therapy work going on.

There's a lot of very promising boutique expensive medications in the pipeline, and that kind of what we're seeing now as the potential trade-off with very, very expensive drugs treating very, very significant conditions is -- you know, we're just at the tip of the iceberg kind of phase.

Do we have a sense of the pipeline at all in terms of kind of when a lot of the particular drugs are going to come to market that are going to really confront this issue even more than we've seen it to date?

MS. ZETTLE: Yeah, so we do have estimates like the 40 to 50 cell and gene therapies, but that could come by 2030. But I think there are also -- you know, outside of the cell and gene therapies, some of the areas that were addressed at the roundtable were around -- and I think Chris might -- sickle cell, hemophilia, some of these -- some childhood conditions as well that could really have a large effect on the Medicaid population.

I think one of the points that got raised on cell and gene therapies specifically is that right now it's sort of like a volatility issue, that one state could, you know, get hit harder or one plan may get hit harder, but as

actually more come out, the predictability issue gets addressed. But then those trade-offs happen with the budget impact being pretty significant.

VICE CHAIR MILLIGAN: I'll come to you and Kit in a second, Toby. I guess part of -- one, maybe two comments, and then I'll turn it over to Kit and Toby. And then, Commissioners, I then want to circle back and try to get a sense of kind of where you might want to take this work going forward.

One of the areas I think where MACPAC has been most successful in terms of fulfilling the duty of helping drive policy and working with Congress on our recommendations is in the drug area. I think we've seen a lot of recommendations get kind of wide acceptance and then kind of get converted into legislation. So I think this is an area where we've been very effective, and you all, Chris and Amy, have been very effective helping with the work. So I do think we want to kind of see if there's a place to make a contribution here.

With a lot of the accelerated approval and a lot of these medications we're talking about, I think disproportionately we're also talking about Medicaid

population because the kind of conditions that lead to the need for these very expensive medications are disabling conditions. They're significant conditions. They're conditions that often take people out of the workforce and often result in Medicaid eligibility in the first place. And so unlike other payers, I think we've seen with hep C, with HIV, with other high-cost drugs over time that Medicaid bears kind of a disproportionate share of the financing burden of the drugs that come to market because of the conditions that lead to Medicaid eligibility in the first place. So I do think this is an area where MACPAC needs to continue to kind of contribute in a leading way.

Kit and then Toby and then Fred.

COMMISSIONER GORTON: So thank you for the work and for convening the roundtable and bringing it. I don't think any conversation about these drugs is complete if all we talk about is money and we don't talk about safety and quality and beneficiary protections. When the FDA approves these things, then patients, their families, and prescribers assume that safety and effectiveness has been demonstrated. I think we have a fairly long list of examples in which, in fact, that's not the case.

And so while MACPAC is not here to advise FDA and we don't have any influence over FDA, I do think we have a responsibility to advocate for Medicaid beneficiaries. What happens in these circumstances is that Medicaid beneficiaries, children with horrible conditions in many cases, end up becoming the unwitting experimental population for the manufacturers, because once the FDA approval is there and the label is there, all of that informed consent and all of those protections that go around participating IRBs, that go around children and people with disabilities participating in experimental trials, the minute the FDA pushes it through and it's a labeled indication, then those things go away. That bothers me. We've seen a whole series over the course of the last generation of wonder cures that have come out, and then they get withdrawn because they're dangerous or in some cases they're lethal for some population, and because they haven't been studied and because sometimes the post-marketing stuff hasn't been done, people's lives are put at risk.

So I do think that if we're going to talk about this, we need to have a discipline about raising

beneficiary protections and this whole question of who's funding -- Title XIX is very specific about experimental care, and this FDA accelerated process, in my view -- nobody else has to agree with me, but in my view is a massive loophole around creating access to publicly funded experimentation in very vulnerable populations. And it creates expectations on the part of families. You look at the Duchenne muscular dystrophy drug, and in the interest of not being sued, we'll just leave it at that. There's not a credible body of evidence that that's safe and effective, either safe or effective, and yet families have been promised salvation for their children, and there's not a family on Earth that won't try and achieve salvation for their children at any cost, and then Medicaid picks up the tab.

You know, so I think there's just something that bothers me a great deal about all of that, and I just think that as MACPAC discusses the issues here, we need to be careful not just to talk about price and budgetary impacts, which are real and meaningful and create all sorts of problems, but also the impact on individuals and their families in terms of being subjected to what in many cases

are unproven therapies.

VICE CHAIR MILLIGAN: Thanks. Toby.

COMMISSIONER DOUGLAS: Hard to follow Kit. So I just wanted to ask, if we were to pursue some of these policy options in particular on the mandatory rebates or the federal match, if, either Amy or Chris, you could talk a little bit more about what would be the analytical framework? How would we given there's so many different levers at play here and I kept on citing the ability to reprice and reset how this would really play out in terms of impact and solving the underlying problems?

MR. PARK: Yeah, certainly I think definitely one of the challenges in any type of analysis would be trying to predict a manufacturer response. We've seen this with some of the recent proposed rules out there on the drug rebate safe harbor, and it's very difficult to know how manufacturers may respond in terms of either, you know, reducing the number of drugs they bring to market, how they'll price the drug in response to some of these policy options.

So I don't think we can ever really truly zero down to the true effect, but I think there are ways for us

to try to understand, like say you brought up the example of changing the rebates on the accelerated approval, so we could identify which drugs are accelerated approval drugs, try to see how much states are spending on those particular products. We've seen studies about, you know, how long it takes for the post-market studies to be done and whether or not ultimately those studies have proven the effectiveness of the drug or if drugs have had to be withdrawn because the studies didn't show what they needed to.

So I think we can do, you know, a lot of that research to help you bring those options forward, things like increased federal match, you know, it's just more trying to figure out how much is being spent right now and what would happen if you shifted spending from states to the federal government. But, you know, there is some difficulty in kind of predicting the overall effects because, you know, the markets dynamics are difficult to predict.

VICE CHAIR MILLIGAN: Fred.

COMMISSIONER CERISE: Thanks for the information. It sounds like it was an interesting panel that you pulled together.

Just an observation. Most of these policy options are kind of ways to deal with the high costs, you know, but it doesn't get at the issue of these drugs coming out that are priced oftentimes not based on the cost of production and R&D but on the opportunity to make a dramatic impact, and so we see these high costs. So some of the things you've identified, you know, the carveout for these particularly high drugs and looking at different policies and a different approach where you don't have competition and, you know, things like looking at what are the costs, what are the R&D costs, what's a reasonable launch price, and perhaps, you know, at a reasonable launch price then you can give some more assurances of exclusivity down the road, longer periods of exclusivity in exchange for, you know, some post-marketing analysis that you're looking for, but something to really get at the -- instead of just kind of reacting around how do you deal with the cost, what's a fair way to pay for the actual work that goes into developing these drugs, but then not to just pay an obscenely high price. I mean, you know, when penicillin was developed, that was a fairly durable cure, too, you know? So the fact that you cure something, I don't know

how that correlates with at a price that well exceeds the R&D cost. But the trade-off may be given some surety for exclusivity down the road if the post-marketing analysis weighs out and you get beyond these intermediate outcomes and it looks like you've got something that's effective and you want for the long term.

VICE CHAIR MILLIGAN: Martha, then Toby's second bite.

COMMISSIONER CARTER: I don't want to diminish at all what Kit said, and I appreciate what you've said about our need for financial stewardship. It would be obvious to say, though, that there are drugs that are lifesavers and you wouldn't want to withhold because they didn't have -- because it was approved quickly or there wasn't a lot of experience with it.

So I'm sitting here wrestling. I don't have a good answer to that, but I think we have to point that out. And I personally have taken a drug before it was FDA approved for a serious condition, and I'm very grateful that I was able to do that. So, you know, where's the balance in all this? I don't know. But I think it's got to be said that that is an important consideration.

VICE CHAIR MILLIGAN: Toby.

COMMISSIONER DOUGLAS: I was just going to say while I agree with what Kit as well as Fred is saying, I just don't see for us being able to tackle that big of an issue, and that's where at least in the short term, given these high costs on states, to be able to at least then both provide visibility on the costs and in one bucket, in certain ways giving it back to the federal government through the rebates or a different FMAP, maybe it will eventually get to solving the bigger issue. But I don't know if we from Medicaid can take on this big issue or move the policy forward, and that's why I would focus a little on some of these incremental steps first.

VICE CHAIR MILLIGAN: Okay. Kit's second bit, and then coming to Melanie.

COMMISSIONER GORTON: So I don't disagree with that. I just don't want the safety and effectiveness -- I don't think we can afford to be silent about that. And I don't disagree with what Martha said, but I believe that should be a different pathway. I think the experimental proof of safety and efficacy should be available. There should be exceptional and compassionate use. There ought

to be a pathway to do that. I don't even have a philosophical objection to Medicaid paying for it under those circumstances. I simply don't think that something should be rushed to market, particularly at an outrageous retail price, list price, for the purposes of compassionate use. There are other solutions to that particular problem.

So I don't disagree that from MACPAC's perspective we need to talk about financing, because it's unmanageable. But I do think that to have the conversation in the absence of discussing beneficiary protections is an incomplete conversation. That's all.

VICE CHAIR MILLIGAN: Melanie?

CHAIR BELLA: Yeah, one question and then a comment, I guess. On the notion of kind of give me more transparency to what's in the pipeline, CMS doesn't necessarily always have that transparency either, right? They would have to rely on FDA to be a good sister partner to tell them, and then they'd have to get that information to the states. What do we think -- how much time extra does that give? And then what is realistic about actually thinking you could do something about it in that time?

MS. ZETTLE: Yes, that's accurate. Our

understanding from the roundtable was that there would have to be some sort of new partnership created.

Another component that came up is that oftentimes drug makers will request meetings directly with CMS to sort of give them some insight into sort of how the development is going, and that that information could be more uniformly shared with the states, which it doesn't appear -- that isn't currently happening as we understand it from the roundtable.

I don't know, Chris, if you have anything else to add on that.

MR. PARK: No. I think that's right. And one thing I should bring up is in the Senate Finance bill they create a value-based payment model over time, and one of the requirements there was for CMS to work with the FDA early in the clinical trial process. Essentially, the manufacturer would declare that they are interested in these models after Stage 2 of a clinical trial and that CMS and the FDA would work together to kind of try to get a model in place by the time the drug hit the market. So I think people are starting to think about ways that CMS and the FDA could work together a little bit more closely to

kind of help develop these strategies so that there's not such a delay when a drug hits the market.

CHAIR BELLA: Okay. Thank you.

Coming back, Chuck, to your question, what I'm struggling with is I'm not -- we've got several different problems we're trying to solve, and these are all -- like they don't -- they're in different buckets, and so for me it's not a question of will we be involved in this. I think we can't help but be involved in this. But what's the right timing? Are there other things, like something happening on the Hill or with any of the other drug legislation going down? Is there going to be a signal to us that there is a more appropriate time for us to pursue this a little bit more? Or should we just go ahead? At this point it feels like we're still more in the diligence stage of kind of assessing some things.

The only thing that we haven't talked about much that I worry about is I do think states are trying to be very innovative in coming up with things, whether it's Netflix or subscription or whatever you call it, or the outcomes based. And if there are going to be more and more states going in that direction and we don't know if those

programs are necessarily working very well, I'd like to -- if there's something we can contribute to that debate, I think it would be helpful before states just start adopting these because someone else is doing it. So I'm not really answering your question at all.

My question is one of timing, and this to me feels a little like we've still got some mixing of ingredients to do to figure out when it's appropriate for us to really go more forcefully in this area.

EXECUTIVE DIRECTOR SCHWARTZ: I think on the timing, there are some Medicaid provisions in the Senate Finance bipartisan bill but not a ton of stuff that is really going to this problem. The feedback that we get from the Hill is, yes, we'd like to see more.

So we don't know how long this round is going to go, but I think there's an appetite for this. We should take our time and do it right. I don't think that the opportunity is going to go away because the problem is going to persist. So if we need to do a better articulation of the market, describing the problems better and sort of matching solutions to specific problems, that's useful feedback. Then we can proceed from there.

VICE CHAIR MILLIGAN: Yeah. So let me try to wrap, and then I'll invite public comment if anybody has comment to share.

It sounds like we're not ready to make any kind of recommendations or anything like that or options.

I do think that one area to keep monitoring maybe with focus is around the drugs that are going through the accelerated approval pathway, both for the -- is it a loophole? Is there integrity to the criteria?

But, secondly, coming back to Kit's comment, after evaluations come in after the fact and making sure that the evaluations in fact do come in, do they meet safety and efficacy kinds of standards?

I do think that monitoring the drugs and the price points of those particular drugs coming through that accelerated pipeline pathway is an area that would be important to keep a special eye on. But I think in general, then, it's kind of how all of the ongoing rebate discussions with the high-cost drugs intersect with value-based contract approaches and some of the elements that Melanie mentioned.

So I think really keeping a focus on and keeping

kind of a current on the state of play of all of that so that we're poised to kind of weigh in if and when it's appropriate, I think, is probably the next best step.

CHAIR BELLA: Can I say one thing?

VICE CHAIR MILLIGAN: Sure, of course.

CHAIR BELLA: All right. Just one last thing. When Anne said like matching problems to solutions, I mean, after hearing Kit talk and others talk, to me, it's almost like a grid, right? And along the top is like "reduces Medicaid spending, reduces overall spending, improves patient safety, improves efficacy, like reduces burden," whatever it is, because these all -- none of them check all of those boxes.

Then we decide. Are we going to focus on improving efficacy and spend, total spend? Are we going to improve on -- focus on Medicaid spend? And kind of thinking of it, I guess in that way would be helpful and then would help us understand like the problem we're seeking to solve at this particular moment, because we want to solve all of them, but I don't think any of these hit all of those.

Sorry.

VICE CHAIR MILLIGAN: That's okay.

And Martha wanted one more, and then if anybody is going to offer public comment.

COMMISSIONER CARTER: It's sort of a nuance and a question.

I think there are drugs new to market, drugs and therapies that are new, and then there are drugs that are already approved for another indication that are then approved for something different. And I think there may be a difference in safety around that situation. So we're lumping them all together, but maybe they need to be thought about differently.

VICE CHAIR MILLIGAN: Does anybody have any public comments on this topic?

PUBLIC COMMENT

* [No response.]

VICE CHAIR MILLIGAN: Okay. Seeing none, Chris, Amy, thank you very much. Really helpful.

And we'll now turn to our next agenda item, which relates to 1115 waiver evaluations.

[Pause.]

VICE CHAIR MILLIGAN: Welcome back, Kacey.

You're not in the Territories anymore.

As a group, we've talked a lot about 1115 waiver evaluations and the quality and timeliness of those evaluations to help inform whether demonstrations are fulfilling kind of the experimental nature of 1115s. We look forward to hearing where the work has progressed.

Kacey?

THEMES FROM EXPERT ROUNDTABLE ON EVALUATING SECTION 1115 DEMONSTRATIONS

* MS. BUDERI: Great. So like you said, Chuck, in this session, we're going to discuss the issue of Section 1115 demonstration waiver evaluations.

As you know, Section 1115 of the Social Security Act provides the federal government with broad authority to waive federal Medicaid requirements, allowing states to test unique policies in their Medicaid program.

Demonstration waivers approved under this authority are subject to evaluation, but historically, state evaluations have not generated findings that are timely or rigorous enough to support decision-making.

We contracted with Mathematica to convene an expert roundtable to explore approaches to improving the

quality and timeliness of state-led demonstration evaluations.

So today I will be providing you with some background information on this subject and go over some high-level takeaways from the roundtable discussion.

MACPAC has discussed this issue on several prior occasions, most recently at the April 2018 public meeting at which we convened a panel made up of representatives from CMS and GAO to discuss the findings of GAO's recent report, which called out multiple issues with evaluation content and processes, and to hear from CMS about the agency's future work to improve evaluations.

Since then, CMS has released new guidance and taken some other steps to promote evaluation quality, which I'll discuss in greater detail in just a few minutes.

So, as of November 2019, there were 62 approved demonstrations in 46 states. These demonstrations differ in scope and the policies they implement. Some cover almost the entire state Medicaid population, while others cover only a small subset. Some have been in place for decades, while others are much newer.

All Section 1115 demonstration waivers are

subject to monitoring and evaluation requirements. Monitoring and evaluation are distinct activities with different purposes. Monitoring activities provide periodic updates on demonstration implementation and basic data on key measures. Evaluations are intended to assess whether demonstrations achieve their objectives and to help support decision-making.

I'll note that although monitoring and evaluation are related, the focus of our roundtable and on this presentation is on evaluation.

So talking specifically about evaluation requirements, there are three main evaluation deliverables: the evaluation design plan, interim evaluation, and summative evaluation report.

Evaluation designs specify the hypotheses and research questions, methodology, and process information, including information on the vendor chosen to perform the evaluation and the budget.

Interim and summative evaluation reports include results, conclusions about whether the demonstration met its objectives, and discussion of policy implications and lessons learned.

CMS reviews and provides feedback on these deliverables and must approve them before they become final, which means that CMS has several opportunities to guide the process.

GAO along with MACPAC and others have expressed concerns about evaluation quality and processes on several occasions. Specifically, several GAO reports released between 2007 and 2019 have found issues related to methodological shortcomings, selective reporting of outcomes, limited opportunity for public comment, and CMS approving demonstration extensions based on incomplete or inconclusive evaluation results.

Congress and CMS have instituted a number of reforms intended to improve evaluation rigor and transparency. The ACA required the Secretary to establish a formal process for evaluations, and the Secretary finalized regulations to do so in 2012.

More recently, CMS has enhanced its efforts to provide individualized technical assistance and feedback to states designing their evaluations.

Earlier this year, CMS published several new resources, including a set of white papers discussing

common evaluation challenges, general evaluation design guidance, and policy-specific evaluation design guidance, which lays out CMS's expectations for the components of evaluation designs for certain demonstration types. And these provide examples of logic models, hypotheses and research questions. They also suggest measures, data sources, and analytic methods that states could use.

Despite CMS's significant efforts to improve evaluations, states and CMS continue to face challenges, including methodological and administrative challenges, timing issues, the difficulty of judging the strength of evidence needed to make decisions, and the influence of outside factors on decision-making.

Our roundtable was intended to gather more specific information on these challenges, solicit opinions on the appropriate balance of state flexibility versus federal oversight, and probe for potential steps that could be taken by states and the federal government to improve Section 1115 waiver evaluation processes.

The roundtable was held at MACPAC's office on November 14th an included state and federal officials, evaluators of several state demonstration programs,

researchers, and other stakeholders. We did not ask participants to come to consensus or make recommendations.

In the slides that follow, I'll go over the main takeaways from the discussion.

Starting with discussion takeaways related to evaluation processes and challenges, participants agreed that CMS's 2019 guidance has been helpful for setting expectations for what's required of states, not only in terms of the content and level of rigor, but also because it emphasizes the importance of states thinking through what they're trying to demonstrate.

They discuss the value proposition for states when it comes to investing time and resources into evaluation, and how this differs by state and is reflected in the evaluation budget, planning efforts, and overall quality.

They observed that state legislatures and other state officials often use Section 1115 as an opportunity for flexibility, as a way to generate cost savings under budget neutrality, or as the longstanding way in which they've operated their Medicaid program, rather than as an opportunity to test or demonstrate the effects of a waiver

policy.

Other states view an evaluation as an opportunity to answer questions or demonstrate a return on investment for state legislatures.

Participants talked about their experiences budgeting for evaluations, noting budgets are often determined based on policymakers' willingness to provide funds rather than by the cost of necessary evaluation activities or components.

While some participants discussed ways of incentivizing states to provide more evaluation resources, such as offering an enhanced matching rate, others noted opportunities for CMS to provide more guidance on setting an appropriate evaluation budget through guidelines or examples.

Some participants felt that the current arrangement in which states fund and direct evaluations may limit the independence of their evaluations.

Participants agreed that considering evaluation earlier in the waiver application and implementation process can help produce stronger evaluations; for example, by involving evaluators in the waiver negotiations.

Acknowledging that states often prefer to wait to procure an evaluator until after the demonstration is awarded, some participants suggested other ways to help states design waivers with evaluation in mind. For example, CMS could improve the application template to help support this or make evaluation-related technical assistance available to states earlier.

They discussed the issue of comparison groups, noting that comparison group challenges can be addressed with better cross-state data arrangements and advance planning. They did acknowledge barriers to both of these approaches. Specifically, it can be difficult to negotiate and establish data use agreements with other states, sharing and using the data can be administratively burdensome.

Additionally, while states that plan ahead can use phased or random implementation strategies to create a comparison group, Medicaid agencies may lack the staff expertise to do this, or they may be constrained by implementation timelines imposed by the state legislature.

We asked participants to consider, given these constraints and issues, what standards might be reasonable

for evaluation content, including methodological features and level of rigor and timing of key evaluation deliverables.

One point was related to the timing of evaluation designs relative to demonstration implementation. Participants discussed how it may not be feasible to finalize evaluation design plans prior to program implementation, but that depending on data needs, states may need to begin some evaluation activities prior to implementation in order to effectively test policies. Specifically, states need to determine if available administrative data can be used to answer the research questions, and if not, they need to collect baseline data.

In general, participants agreed that evaluations should include beneficiary surveys or another method of capturing data that cannot be captured using administrative data, and that this is particularly important for demonstrations that are testing whether beneficiaries changed their behavior in response to policy.

They acknowledged the expertise and resources needed to conduct a strong survey and noted alternative approaches, including using data from other programs or

conducting targeted focus groups or systematic stakeholder interviews.

Several of the evaluators and researchers attending agreed that greater collaboration among evaluators would be helpful for improving skills, sharing lessons learned, and establishing collective standards of rigor in ways that are specific to Medicaid demonstration evaluations.

Participants discussed the data challenges resulting from current timing requirements for interim and summative reports and talked about some potential opportunities for flexibility. Data collection periods for three- or five-year demonstration programs may be inadequate to assess the effects of a policy. This is particularly the case for interim evaluations, which need to be submitted at least one year before demonstration expiration.

Both evaluators and state officials noted that in light of this challenge, a more appropriate focus for interim evaluations could be on implementation, and that interim evaluations could collect information on process indicators: For example, an interim evaluation of a work in

community engagement demonstration could include the share of beneficiaries who know about the incentive or requirement, rather than to try to use a limited amount of data to assess whether beneficiaries were more likely to gain employment or receive an officer of employer-sponsored insurance.

Participants also noted that standards and requirements related to content, rigor, and the timing of evaluation deliverables could vary by demonstration type and scope, and that CMS may want to vary these standards based on the risk of beneficiary harm, novelty of the approach being tested, the strength of existing evidence, federal investment, or some other criteria. However, some participants, including officials from CMS, noted the difficulty of defining and uniformly applying criteria in this way.

Participants discussed several points related to the level of evaluation evidence needed to inform policy. They noted that evidence is lacking on the effects of many longstanding demonstration programs, citing retroactive eligibility waivers and nonemergency medical transportation waivers as examples of demonstrations that have been in

place for years but have received minimal attention from evaluators.

They also noted that we currently have no mechanism to determine that we know enough about the effects of a demonstration policy to say that it should either be incorporated into the state plan or not used at all. Several participants observed, for example, that longstanding managed care demonstrations that are not seeking to demonstrate something could be incorporated into the state plan.

Another participant brought up premiums, noting that such policies continue to be approved under demonstration authority, despite the large body of evidence on their effects.

Additionally, evaluations do not capture a demonstration's effects on other aspects of the health care system or safety net, which can be significant, and finally, evaluations may be limited in what they can tell us, even when they are robust and timely, as one state's experience may not inform another's, given state-specific circumstances, differences in implementation design, or other factors.

And then to round out the discussion, participants raised issues related to transparency and public comment with evaluations. They noted that states have the opportunity to use public comments to inform evaluation designs, and that some states are actively doing this. Representatives of two states described using public comments to identify areas of risk that should be evaluated.

They also discussed how evaluators, states, and CMS could improve transparency by more widely disseminating evaluation products and by working to ensure that findings are made easier to read and more understandable by lay audiences.

So I'll stop there. I'll just note that this is a high-level summary of the discussion takeaways, and it's not inclusive of every point that was raised during this all-day discussion.

The next steps for this work could include a chapter in the March 2020 report to share this information in more detail and with a broader audience. So it would be helpful to get your feedback on what we learned from the roundtable, whether there are additional areas for

exploration and what findings to highlight.

So I'll turn it over.

VICE CHAIR MILLIGAN: Thank you, Kacey. Commissioners? Bill. Thank you.

COMMISSIONER SCANLON: Thanks very much. That's very helpful.

I think there's no issue about sort of the variability in evaluations over time, and the question in my mind is that while we can identify areas that could be improved, there's an elephant in the room, which is: Are these really demonstrations, or are these deviations from statutory policy that are desired and somehow have gotten through an approval process? And this goes in particular to some of the very longstanding demonstrations, goes to the examples that you gave about things being approved, and we've got evidence that they don't meet certain goals.

So there is this issue about if we invested a significant amount of resources in making sure evaluations are done well, then when we get the results, what are we going to do with the results? CMMI has very specific criterion for if something is demonstrated to be cost saving, then it can become a permanent part of the program.

In lieu of sort of going to the Congress and saying we've demonstrated this and there's value, would you consider enacting it? We have a precedent in terms of an alternative.

This has evolved without explicit sort of recognition of what we're doing, I think. And so I kind of am always left here, where are we in terms of the activities that are occurring under 1115? Which of them are genuine demonstrations, which of them are program changes, and how should we treat them, either separately or collectively in the process? And that for me raises a lot of questions about what we do with respect to evaluations.

VICE CHAIR MILLIGAN: Thank you. Others? Toby.

COMMISSIONER DOUGLAS: Well, the roundtable, the participants really raised a lot of great insights or insights that really need to be brought to a head, and kind of agreeing with Bill, just from a different perspective of when states do 1115s and especially from a governor policy, it's really just through the lens of how are we changing -- getting around state plan rules and being able to execute. And so we have this disconnect here. As we sit here, we see 1115s through the lens of demonstration and evaluation,

and the states, those who are holding the budgetary financial strings are not viewing it at all like that. And this came out clear in the roundtable.

And so if we really want to get to the fundamental issue, either we take what Bill says, they're not really -- they're not evaluations or demonstrations, but if we do keep it in that construct and we want a rigorous evaluation, there needs to be some way to better connect what's going on in the state from a policy and budgetary standpoint and the requirements that are truly part of an 1115. And it's not just about an ability to waive certain rules, but it is about an evaluation and demonstration because that's the huge disconnect, and right now states don't invest or really have much interest in the evaluation other than seeing it as a perfunctory process, and what they care about is the waiver of the rules that get them either financial or changes such as work requirements to be able to implement.

VICE CHAIR MILLIGAN: Thanks. Fred?

COMMISSIONER CERISE: Yeah, what Toby said. I agree with these guys. It seems like we have to determine are we talking about true demonstrations or not. I can't

imagine we have a real demonstration project that you're approving without an evaluation plan that comes later. And so if we are serious about that -- and somewhere in the writeup, there's a good description of that. Like, you know, maybe we need to stratify these things, and the things that are true demonstrations, like you're really changing practice and you want to know if that's effective, then that has a higher level of scrutiny to it. But it does make me -- you know, earlier we talked about directed payments and these new supplemental payments that we're going to have evaluation plans around, and it concerns me that we're going to layer more evaluation plans in the program when we're not doing it for the real demonstrations.

VICE CHAIR MILLIGAN: Thanks. Darin?

COMMISSIONER GORDON: You threw me. You looked over there and said, "Darin."

[Laughter.]

COMMISSIONER GORDON: I think Toby's right. However, I think some of these things do start out as a true demonstration, and they really do -- the genesis of those programs are there. But then at some point -- and

we've had a discussion for years, like we've proven it's better than what we were doing, do we just stop? I mean, no, we're going to continue. And do we need to continue evaluating? We've talked about this. When I was there, it was like we're going to continue to evaluate this approach or this model in the 20th year of doing this and seeing if the impact continues.

So it's a little bit like what Bill was saying. You know, we talk about this path to permanence, and, you know, we've talked about it in multiple administrations, that, you know, at some point some of the waivers you have looked at, it does produce different results than the results you were hoping to achieve and at a budget-neutral rate. Do we need to keep doing an evaluation plan on it at that point? I would argue I think we need that tiering, I think someone had recommended, and saying at some point these things get into a steady state.

VICE CHAIR MILLIGAN: Tricia?

COMMISSIONER BROOKS: Well, it's an interesting conversation, and I'm glad to see the recognition that so many waivers that are being approved are really flexibility and not demonstrations. Has MACPAC ever commented on that?

I mean, it seems that the administration continues to exceed their authority to approve demonstrations -- I mean, how many demonstrations do you need of work requirements, right? We've approved, what, 10 or 11? South Carolina approved for the first time today work requirements on parents. That has not been done before. And I know none of these have been implemented, but I think the question is, you know, where do we stop doing approvals of demonstrations until they demonstrate something. And then it should be codified in some way.

VICE CHAIR MILLIGAN: Darin, and Anne if Tricia's partly asking about MACPAC's history as the historian.

COMMISSIONER GORDON: I just want to make one comment on that. I do think that it is appropriate for different -- flexibility and demonstration I don't think are mutually exclusive. I think, you know, sometimes you're trying to test whether or not certain flexibilities lead to a better result. But having it done in multiple markets, you know, we did this in managed care for many years, different states doing it and slightly different approaches. I also don't think we should say, well, someone else is testing, you know, if we went backwards,

managed care so nobody else should do it, because they're very nuanced and slightly different. There's different geographies in states, different populations, et cetera. So that's just like a little asterisk to what you had said.

COMMISSIONER BROOKS: And I would agree with that, but do we need 20, you know, I mean, to get the variability there?

VICE CHAIR MILLIGAN: Anne.

EXECUTIVE DIRECTOR SCHWARTZ: In terms of what we've done in the past, obviously most recently we sent a letter to the Secretary last fall regarding the Arkansas demonstration and Commissioners' concerns about the number of people losing coverage. A strong point in that letter was not on the merits of the work requirement, but concern about people losing coverage, and also the fact that there wasn't an evaluation plan in place.

We have talked about waivers and evaluations at several points. We've also talked about this notion of a path to permanence. We did a series of recommendations around streamlining managed care authorities because now there are state plan opportunities to do managed care that there weren't in the past and to be able to streamline and

remove some of those requirements. We have not made recommendations specific to 1115.

VICE CHAIR MILLIGAN: Brian.

COMMISSIONER BURWELL: I'm going to show my age and I was going to tell two stories. So back in 1980, not every state was in the Medicaid program. There was one that was not, and that was Arizona. And Arizona basically wanted to make a deal with HCFA at that time and said, "We'll come into Medicaid, but we'll only come in if we can do all managed care." And 1115 was the mechanism available to do that. So it has always been this was not a demonstration. There wasn't any, you know, comparison group, and ever since it's been a mechanism to do programs. I mean, so it's almost like do we need a different structure? Do we need one that's more kind of program oriented and we just want to make changes, and it should be the one that's more towards research and demonstrations.

On the demonstration side, I'm also old enough to remember something called the "channeling demonstration" back in the 1970s, which was actually supported mostly by ASPE. It was a 50 million demonstration. I think Bill remembers it. It was a randomized design to test whether

home and community-based services were a cost-effective alternative, and if you covered HCBS, would you end up saving money? The result of this 10-year evaluation conducted by Mathematica was, no, it's not cost-effective, because most people who are served under HCBS would not be in a nursing home. Did it have any connection to policy? Here we are, you know, 30 years later, and we spend $45 billion on HCBS. So, I mean, maybe it was worth doing anyways, but I'm just saying, you know, demonstration evaluations don't necessarily always lead to better policymaking.

VICE CHAIR MILLIGAN: Bill's name was invoked.

COMMISSIONER SCANLON: And actually Brian and I were exchanging at lunchtime. I'm even older, so I remember Arizona. And as I remember it, it was a big deal when the five years were up, when their first 1115 for them to demonstrate that the next five years we going to be different than the first five years. This was going to be not continuing the same demonstration but a different demonstration. So I think we've gotten away from this idea that you need to evolve in significant ways. So there's that aspect of it.

But go back to Darin, I mean, the path to permanence, it makes sense, okay, but we need to have the criteria for when it makes sense. And then you would sort of stop calling this sort of a demonstration, and you would call it the program, so to speak.

You know, we fall into these traps when it's convenient of misusing words and terms and statutory sort of provisions when they're convenient for us, but then it turns out at times someone else finds that using them in a different way is very inconvenient for us or uncomfortable for us. And so I think it would be better if we would consider this in terms of if there is this need for program flexibility, which I'm not going to dispute at all, there's a question about what should be the criteria for, one, initiating it; two, potentially with tests; and, three, allowing it to continue. Because right now we're going through essentially these fictions that they're not necessarily sort of causing harm, but they are probably in some instances causing harm. But they're certainly wasting our time in terms of trying to develop sort of ways to work around that shouldn't necessarily be there.

VICE CHAIR MILLIGAN: Stacey.

COMMISSIONER LAMPKIN: Thanks. I think what you said, Bill, makes a lot of sense, and I was going to say that the path to permanence conversation has come up before, and it does seem like an area worth exploring with respect to what does it take to get there. But it doesn't feel to me like we have to set the questions about the evaluations aside until we solve that problem, that there's still learning to be had from the conversations that we had in the roundtable and how we can strengthen these, and maybe they're even part of helping us get to criteria for path to permanence if we wanted to go down that path. But just discarding good evaluations in the meantime seems -- it seems like there's still something we can do with this great information that we collected at the roundtable that adds value to the policy conversation today.

COMMISSIONER SCANLON: Right. I would say whenever it's appropriate to have an evaluation, it should be a good evaluation. It's just what we're talking about now potentially is we're going to universally have evaluations, sometimes where they're needed and appropriate, and other times where it's just a waste of resources.

VICE CHAIR MILLIGAN: Are there -- Anne?

EXECUTIVE DIRECTOR SCHWARTZ: So one thing that came up at the roundtable -- and we had a really good November. We had these two really great roundtables. I learned a lot. One thing, you know, when we have these conversations about path to permanence and then when we were talking about the 1115s in general, I think we tend to sort of thing lump them all together. And I think one thing that was really clear in the roundtable was how different these different opportunities are in terms of both what they're trying to achieve programmatically, and also what was actually being waived and what was being demonstrated, and then how that affects the evaluations.

So, for example, in Kentucky, which has both an SUD waiver and a personal responsibility waiver, it actually had a big effect on program design, too, because on the personal responsibility one, they were going to do a phased implementation. They had some counties kept out of that as their comparison group in order to test that. But on the SUD side, they didn't want to do that because of the harm to beneficiaries of not being able to take advantage of expanded treatment while they're waiving the IMD

exclusion, the real main focus of that was to use that as the carrot to have statewide planning around provider capacity and developing a continuum of care. It wasn't so much that was being waived there.

So I think that's something, if we do some writing on it, I think we really need to pull out and be careful about it. I think also then if we want to have more discussions around path to permanence to talk about these not in an authority-wide way but in a really discrete way. Because you could say doing managed care under state plan authority is a path to permanence, but there are reasons why states that are doing that under 1115 don't want to do that. So it is a path to permanence, but it may not be appealing. So I think that we have to be careful and nuanced as we talk about those issues.

VICE CHAIR MILLIGAN: Sure. So I want to maybe try to propose a way to pull this together and to just kind of get a sense of the group.

It sounds to me, just listening, that, Kacey, I think trying to get something together for a March chapter I think would be a good thing just to kind of collect what you share today and what you heard at the roundtable, and I

think also to reflect some of the different types or the kind of tiers or whatever the word is, but, you know, different approaches or rationales. You know, maybe some is really flexibility-based, some is more demonstration-based. But I think kind of something descriptive in the March report that would also reflect -- I do want to acknowledge I think there's been progress in the evaluations. I think what has come out recently in some of the guidance and has come out recently in some of the evaluations is higher quality and more responsive than what used to be the case.

I do think, you know, without trying to resolve but at least, you know, identifying that the relationship between the evaluation and kind of the notion of permanence is an important logical connection and that, you know, we'll continue to -- policymakers will continue to grapple with. I think that that's useful to just reflect and not try to resolve personally.

Not necessarily for the chapter, but I do think when we talk about path to permanence, it's important to distinguish a couple of things. There's one version which is in a given state, the Arizona example or a Tennessee

example, the path to permanence might be how in that state its demonstration becomes permanent.

There is a separate path to permanence which is how something becomes statutorily everywhere, which is maybe more like kind of what happened with welfare reform, where there are a whole bunch of states doing 1115s, and it did lead them to, you know, welfare reform legislation or to the PACE program or others. So I do think -- maybe Tricia would mildly disagree -- there's some value in having it in a bunch of places because then you can say is it generalizable to change the statute. Those are different versions of path to permanence to me. I wouldn't propose writing a 900-page chapter. I do think reflecting what came out of the roundtable and just the way that evaluations have progressed is important to capture. And I think acknowledging that it leaves open certain questions around flexibility versus demonstrations, permanence, all of that, I think that would be a good contribution.

Does that make sense to people? Does anybody oppose trying to just have a good March chapter that is descriptive in that way?

[No response.]

VICE CHAIR MILLIGAN: Okay. I will see if anybody has public comments about the 1115.

PUBLIC COMMENT

* [No response.]

VICE CHAIR MILLIGAN: And seeing none, sounds good. Kacey, thank you very much. Those of you Commissioners who participated, thank you for doing that.

We're going to take a 15-minute break and restart at 10 of 3:00. Thank you.

[Recess.]

CHAIR BELLA: All right. We are going to reconvene. I will give everyone a minute to take their seats.

[Pause.]

CHAIR BELLA: All right. Good afternoon, Kristal. You want to kick us off with Medicaid Estate Recovery please.

MEDICAID ESTATE RECOVERY POLICIES

* DR. VARDAMAN: Good afternoon, Commissioners. The Commission last engaged in Medicaid estate recovery-related issues in 2015, with the publication of an issue brief, specifically on the implications of estate recovery

for the new adult group. We thought it would be a good time to revisit this topic, given recent media attention to this issue, and hope to engage the Commission's interest and potential work to update analyses in the literature that are quite old at this point.

I will begin with some background on estate recovery policy and program administration and then present some new data we have. I will then discuss policy considerations and options and end with some potential next steps.

Medicare estate recovery involves recovering assets from beneficiaries' estate for care that was provided to them. In 1993, the Omnibus Budget Reconciliation Act, or OBRA, made it mandatory for certain beneficiaries.

For beneficiaries who received Medicaid when they were age 55 or older, OBRA specified the benefits for which states are required to seek recovery. That includes nursing facility services, home- and community-based services, or HCBS, and hospital and prescription drug services provided during a stay at a nursing facility or while receiving HCBS. When benefits are covered under

managed care, states are required to seek recovery for some or all of the premiums paid on behalf of beneficiaries. In addition, states have the option to seek recovery for any other items or services under the state plan.

In terms of exemptions, states must exempt or defer recovery if a beneficiary has a surviving spouse, a child who is under 21, or a child of any age who is blind or disabled. So by deferring recovery it would mean, for example, that if a beneficiary had a surviving spouse, the state might delay recovery of, for example, assets from a beneficiary's home, until after the spouse's death.

States can waive recovery if it is determined not to be cost effective. In practice, states minimum thresholds vary, as you can see here between Texas and Georgia. In Texas the threshold for pursuing estate recovery is estate with a value of $10,000 or more. Georgia only looks at estates that are at $25,000 or more. In addition, Georgia also waives the first $25,000 from recovery for an estate that exceeds that amount.

OBRA also required states to establish procedures for waiving estate recovery due to hardships, based on criteria established by the Secretary. The Centers for

Medicare and Medicaid Services provides examples states should consider in the Medicaid manual, but does not require states to incorporate any of them into their hardship waiver process. So, for example, one example is if an estate is the sole income-producing asset of survivors, such as a family farm or other family business.

There is limited data available on how often states grant hardship waivers. A survey of states on fiscal year 2005 practices found the number of waivers granted varied widely, with an average of 27 and a median of 8 with the states with available data.

In terms of program administration, estate recovery involves a number of steps, including informing survivors of claims, initiating recovery through the probate process or other means, and providing hardship waivers.

OBRA requires states to attempt to recover, at a minimum, all property and assets that pass to heirs under state probate laws. However, both the definition of an estate and the priority of Medicaid's claims against an estate's other creditors vary by state. That means that a state might not recover any funds if the estate was first

depleted by other higher priority creditors such as unpaid tax bills.

In regard to program administration costs, an analysis by the Office of Inspector General found that administration costs were just under 7 percent of total recoveries in fiscal year 2011 in states with available data.

Probate collections are reported on the CMS-64 expenditure reports that states file with CMS. We were able to update the figures for recent years and the complete results are in an appendix in your material. In fiscal year 2018, Medicaid programs reported collecting approximately $723.9 million from beneficiaries' estates. That was equal to 0.56 percent of fee-for-service spending on long-term services and supports, which, as I noted earlier, are the benefits for which states are mandated to seek recovery. This is consistent with prior analyses published in the mid-2000s, although amounts have grown in absolute dollars.

One thing I will note here is that more states have managed long-term services and supports now than they did then, and our data do not include capitation payments

made to managed long-term services and supports plans. We expect that if such data were available and included, the estate recoveries as a proportion of national LTSS expenditures would be somewhat lower.

There is very little information available on the size of estates recovered. The only estimate that we found comes from a survey published over a decade ago, which found that the average national recovery amount was $8,116, where the fiscal year reported was generally 2003.

So the questions we would like to set up to guide your discussion are on this slide. First, is estate recovery having its intended effect? Prior to the passage of OBRA, supporters stated that it could ensure that Medicaid funding was used for the needy and replenished program funds as they were spent on other beneficiaries.

Second, given the relatively low size of the average estate recovered, there is a question of whether beneficiaries with larger estates are receiving hardship waivers or exemptions -- again, that data that we have now is quite old -- or if they were able to protect their assets from estate recovery through estate planning.

The third question is, as critics of the policy

argue, is the estate recovery overly punitive to those with few assets?

And finally, given that there is quite a bit of state variation in the size of estates pursued and policies on hardship waivers, there is a question of whether that is equitable given that estates of similar size often face different consequences, depending on the state of residence.

Here we have displayed some potential policy options. First, were Congress to revert estate recovery back to a state option, as it was prior to OBRA, we expect that some states could potentially opt out. Next would be setting a federal minimum size of estates pursued. Third would be waiving a certain portion of assets from estate recovery, as I noted it is done in Georgia, which made that change in 2018. We are not aware of how many states have similar policies.

Another option would be to establish federal standards for hardship exemptions to reduce state variation. States could also be more proactive in assessing whether heirs might be eligible for hardship exemptions, and a final option would be to eliminate estate

recovery.

So today we are interested in your feedback on if the Commission is interested in engaging in this issue, and if so, what analyses would be most useful to inform the Commission's discussion and evaluation of policy options. For example, we could conduct some interviews with states and other stakeholders on program administration and stakeholders' views of the policy. We could also compile information on state notification practices and hardship exemptions. And as I noted in a few points in this presentation, some of the available information we have is over a decade old, so we could also survey states to compile more recent information on estate recovery program administration costs, the number and size of estates pursued, and other state policies.

And with that I will turn it back to the Chair. Thank you.

CHAIR BELLA: Thank you, Kristal. I want to start just by setting context on why this is of interest to me and why I thought it would be worthy of the Commission considering it. When I think about this, there is a lot of attention right now to surprise billing, and to me this

feels like a version of surprise billing for our low-income population or a low-income population family, and the attention on surprise billing for commercially insured folks or higher-income folks whose significant -- and we worry about balanced billing sort of for this population but we haven't really looked at things like this that have a real impact on particular subsets of our population. So that is putting you inside my head of one way that I see this.

The second piece is, we do have a responsibility to look at access. This could have a chilling effect. The Commission has talked, in the past, about policies that have chilling effects. So I do think it fits with the potential access points. The last time we talked about that and a chilling effect was in the context of the public charge rule, and that was something that was a concern for us.

And third is we also -- there has been a common theme lately that states don't have a lot of bandwidth, they don't have administrative capacity. And so if we are looking for opportunities to provide choices for them to make about how they spend limited administrative resources,

this seems like a fair area to say, should we go back to making an estate option so they can choose whether to spend resources on this or not?

I don't know the rationale for making it optional to mandatory, and maybe someone does, and that would be helpful, but I am not necessarily of the opinion that we should eliminate it wholesale, but I do think it's worth talking about -- what is the harm if we let it go back to a state option and/or if we looked at some of these other policy options?

So with that I would love to kick off to the Commission, starting with Kit.

COMMISSIONER GORTON: So it doesn't feel like surprising billing to me, but I just don't see it that way. The way I see it, which nobody else has to agree with, is that state and federal tax dollars coming from huge numbers of families who will generate no estates because they don't have enough income to be able to put aside wealth to pass to the next generation is now, in my view -- and again, nobody has to agree -- subsidizing people who have figured out how to create assets which they would like to keep and still use publicly funded services.

So for me, there is a fundamental economic justice question here about who should pay for whose inheritances. And I think that is a profoundly value-based judgment, and so that would lead me to say, to your final question, maybe it should be a state option, right? States are trying personal responsibility. They have tried lots of other things. If this is something that a state feels strongly about, perhaps it is a state where there is a past history of more asset protection than in other states, you know, certainly the family farm -- although my understanding of the demographics of that is that the family farm is a vanishing entity. But there are family businesses certainly.

And so I don't know that the Commission needs to get into the middle of that, and I would just say, with respect to the first question, I do think that we need to be very, very cautious about treading in values-based policy decisions.

That said, I agree with the premise. We've talked about various program integrity mechanisms, and some of them work and some of them don't, and some of them have a return investment and some of them don't. This one

actually seems to have a decent return on investment, but it is a small investment and so you get a small return. But $723 million is not chump change. And so to the extent that a state thought that was important to be able to do that, I think, again, they should have the option to do it. It should not be prohibited.

So for me, though, in order to answer any of these questions, Kristal, I think we need to know how important this is to what states. I mean, I do think we need, as we have done with other program integrity things, to go back and say to the states, is this burdensome? Would you opt to continue to do it if were made voluntary? Would you like it to be made voluntary? Should it be changed in some way that would make more sense in your state's environment than in some other state's environment? So I think it is useful to find out about that.

I would like to dig down into the data. I mean, Medicaid is a program for people with low incomes and disabilities. So I am not surprised, necessarily, that the estate amounts that are recovered are low. These are not high-asset people. And in many states, at least, you have to divest your assets, in one way or another, in order to

even qualify for the program.

So I think we should double-click a little bit on the data and the profile. Are there state-to-state variations? Do we have a handful of states where there are large numbers of recoveries and then the rest of the states where there are no recoveries? I would like to have some more understanding of the experience since OBRA in order to get a sense of, is there any there there, and to inform what we might recommend.

COMMISSIONER SCANLON: Yeah. Again, it's displaying age. I think this goes back to the '80s again, and at that point there were some individuals that were very vocal about sort of the problem of estate divestiture, and sort of on the part of nursing home residents. They wanted you to believe that nursing home parking lots were filled with BMWs that were owned by the residents. And that was probably sort of abetted by the fact that there were attorneys saying, "We can set you up so that we can protect your assets and still make you sort of Medicaid eligible."

So I think that was the motivation. But when we did studies, and there were studies done, as Kit pointed

out, it was a poor population that was in the nursing homes, and there weren't assets that were significant to recover. I mean the $723 million is consistent with the number you gave, which, I mean, there is $128 billion being spent by Medicaid on LTSS right now, so $723 million is less than 1 percent.

I think the issue here, in part, is how worthwhile would it be to start to really work on these -- I mean, this is kind of a little bit what I was saying in the prior session -- work on these particular sort of policies?

When we talk about sort of making it optional, the question is, is it already optional? What happens to a state when it doesn't exercise vigorous effort to recover assets? Okay? I can't think of any kind of intermediate sanctions that CMS is going to impose on the state for not being aggressive about sort of their estate recovery.

So I guess I'm wondering if estate recovery programs, by states, are already being conducted in accord with what the state thinks it is worth for them to do, and if that is the case, what do we want to change? Because it may become a whole lot more complicated if we start to say,

here are criteria for making it optional and here are criteria for oversight, and, you know, the status quo may actually be better than some of the things that we might decide.

CHAIR BELLA: Brian, and then Toby.

COMMISSIONER BURWELL: So like I said, this is an area that I worked on quite a bit in my younger years, and so I have depth and perspective. It is an area that people have very strong value judgment opinions about, one way or the other, in terms of whether people who are on Medicaid should be able to pass on the family home to their children rather than have Medicaid recover the costs. And the article in The Atlantic that sparked this is very much focused on a woman who took care of her mother and lives in the family home, and Massachusetts Medicaid has put a lien on it, and, you know, she is going to be made homeless.

The reason why there is not that -- you have to remember, there is not that much recovered from Medicaid estate recovery program as if there is not anything left in the estate at the time the person died. And estate recovery is only half the picture. You can't really study estate recovery without studying also Medicaid planning up

front, because the whole objective of Medicaid planning up front is to get money out of your estate so it is not subject to estate recovery at the end.

And everybody at this table, I know, has gotten flyers from elder law attorneys, saying, "Come to our seminar and keep Medicaid from stealing your house." And there is a very robust industry still out there who make a lot of money off rearranging your portfolio so that if you need long-term care, your house is protected and your inheritance is protected. There is no doubt about that. How much it is, is still, you know, subject to lack of data.

But it is generally about the house. So you have to remember, the house is exempt in the eligibility process. You can get on Medicaid and still have a primary residence. And this goes back to SSI rules and this is part of the problem. The asset test for Medicaid LTSS still come from the SSI program. And, you know, so there is an issue about whether they are appropriate.

So the issue around estate recovery is what states do to -- if there an exempt home, and for the person receiving LTSS, do you recover it upon the person's death?

And then what do you do to protect that, which has to do with the imposition of liens on the house. Do you put a lien on the house at the point of eligibility or do you put it on at the point of death? And what are the rules around liens and people not being able to sell the house. I mean, that is an area that I think is worthy of, you know, where states are.

What states would do in the absence of the mandate, I totally agree it is kind of optional now. You can do a lot. You can do a little. The devil is in the details about how states go about that, and to me this is very much a local culture issue. When I was doing the work, Oregon had a very effective estate recovery program, which they had run forever, and somehow they had gotten the culture in Oregon, which is yes, we will give you Medicaid and we will pay for your services, but, you know, this is a means-tested program and you are going to owe us at the end. And the percentage of recoveries -- and they just had a very longstanding, very well-run -- and they put resources in it -- estate recovery program, and they recovered a lot. And so if every state recovered what Oregon had recovered, it would be a lot more money. So the

same is true now. States can do a lot or they can do a little. It is up to them, and it is very political.

When the law went through in 1993, and mandated it, there was some resistance to state. And there was, particularly, in Michigan, who said, "No, we are not going to do this. We don't care what you say," and they eventually came in around 1990. But I am sure that was from -- it wasn't the state. It was the advocacy groups that didn't want to recover.

So, you know, there are strong arguments to be made on both sides. I mean, people will say, "Why should, you know, children of Medicaid recipients be able to inherit a $500,000 house when a single mother with a kid can't have more than $2,000 in the bank and be eligible for Medicaid?"

And I have had many Medicaid directors tell me, "You know, I run two programs. I run a very draconian, you know, means-tested health insurance program for really poor people, and I run a middle-class LTSS program." And that's just the reality.

So, you know, it's a value judgment of, you know, what kind of program do we want to have for Medicaid? The

long-term care insurance industry, which is going down the tubes, as everybody knows, strongly thinks that the reason why long-term care insurance has never taken off is because it's too easy to get on Medicaid. And they have always been behind the scenes, you know, pushing for greater stringency in terms of reducing the loopholes around Medicaid planning and so forth.

I think they are personally wrong about that. I mean, I agree that most of the people who receive LTSS on Medicaid are poor people, and not a great percentage have homes. But there is -- there's more money there than people think, and there is an equity issue around, you know, protecting inheritances.

CHAIR BELLA: Kristal, can you put up your second-to-last slide, just the policy considerations?

I'm not suggesting we get into a values judgment. I am suggesting the first bullet, in particular.

I was Medicaid director. Two weeks into the job, I got my first postcard inviting me to a seminar to shelter assets. So I get it, and as Medicaid director, it's super frustrating.

But if the industry of people helping shelter

assets has continued to flourish -- and then I think it's worth asking periodically is it having the intended effect, as opposed to a very proactive expectation around this program that if you use these services, this is what happens in return, and that it's applied equitably, not just for people that can afford attorneys to shelter their assets.

So, if nothing else, I want to keep bringing us back to this. Is it having its intended effect? Do we know? Maybe not. Do we want to investigate it more? Maybe we do want to talk to some states or some beneficiary advocates, but it's nothing more today than kind of revisiting because we haven't looked at it for a while.

Is this doing what we want to see doing, particularly as LTSS is continuing to grow?

Darin and then Chuck.

COMMISSIONER GORDON: Well, she said Darin, so, I mean --

CHAIR BELLA: You can go after. Sorry.

COMMISSIONER GORDON: I agree with Brian. I mean, there are definitely two strong sides to this.

I do think the point, Melanie, you made about

like the parallel that surprise billing that someone said, I don't see it that way. But the way that I -- when you said the thing that I thought of, states -- and I say that knowing that we didn't; I know it's probably true elsewhere -- were not really good about helping inform people really clearly what that meant when they signed the documents to get on the program. So I think the degree to which it's being communicated is probably variable from state to state.

The biggest pushback we had when we actually try to make sure we were doing our responsibility with this -- and our legislature passed a law to make people have to get a waiver from -- not a waiver, but a form from TennCare for any estate to be closed really improved the process. But we're getting pushback from all the estate planning folks that this was creating some challenges for them.

So I agree. Two sides of the issue, I think, and very strong opinions on both, but I do think there's variability in its application. And I do think from a member communication effort that there's probably more that could be done there as well.

COMMISSIONER BURWELL: I'd like to follow up on

that.

I believe the communication part because a lot of the horror stories that get out in the press are the children who -- all of a sudden, the mom dies, and then they get a letter from Medicaid saying, "You owe us $125,000," blah-blah-blah. We never knew this.

CHAIR BELLA: That's my surprise bill analogy that no one likes.

Toby?

COMMISSIONER BURWELL: Well, wait a minute.

But if you do it up front and you say, "Yes, you're eligible for Medicaid. We're going to put a lien on your house," I know a number of people said, "No, thank you." So there is a --

COMMISSIONER GORDON: Yeah. Then that gets to the second point that I think Melanie brought out about its impact on people utilizing the service.

We had a state-funded program for much smaller supports run by the area agencies on aging and then we had our program, and for the longest time in the early years, we were wondering why they were taking off and we weren't. And when we went out and talked to people that were helping

people enroll, it was the estate recovery piece that pushed them over here.

Again, I agree with Melanie. It's something that it's one of these things we haven't touched on, and a lot of it, we probably should just look at. Is it having any effect, and are there things that we can make recommendations on as it relates to it?

COMMISSIONER DOUGLAS: Yeah. So I think from what we have now, we don't know if there is a problem, which to me -- as well as there's not a lot of data and information. So I think taking some incremental steps or surveying to understand what states are doing to be able to answer some of these questions around policies as well as the impact would be worthwhile.

I do, however -- and this is maybe getting a little defensive, but from a state perspective, the estate recovery rules are the rules. You have public servants. When I had a lot more hair and ran a state Medicaid program, we had staff who had to follow the estate recovery rules. It isn't an ability to just pick and choose. The law is the law, and they have to follow it. We have to follow it. So I don't want us to think that states are all

over the place on this. Whether it's a left leaning or not, you've got to be a public servant and follow it. So I think we just need to know what's going on there.

CHAIR BELLA: I'm looking at the folks who have been talking. They've been around for so long. Does anybody remember Toby having hair?

[Laughter.]

CHAIR BELLA: Chuck?

VICE CHAIR MILLIGAN: Wow.

I guess maybe in some ways I'm ready to act quicker than others. I like the idea of the state option, and if we need to kind of build a stronger evidence base around what's going on in the states and the administrative burden and all of that, I think I'm supportive of kind of getting a more evidence-based approach to evaluate whether my impulse is represented in the data.

I was just pulling up online the recommendation we made back in June to make optional for states the recovery audit contractor process. We do have examples where we have taken -- made a recommendation to take a mandatory requirement and make it optional because of administrative burden. I think this, to me, might find its

way down that path.

I want to start there. I want to also go a little bit to the equity and justice pieces of this. I think estate recovery is wrong. We don't do that with other public government programs. People who use Medicare benefits and spend thousands and thousands of dollars in end-of-life care, we don't take their house. People who have Social Security benefits, we don't take their house. There's a lot of discussion about the estate tax or death tax. As a social value for whatever context this has for Medicaid, we have decided in our public policy that inheritances are bad.

I do think that -- you know, Melanie has used the surprise billing analogy. The analogy that comes to mind for me is public charge, which is do we chill somebody's willingness to use a public benefit they are entitled to because of the prospect of having to pay it back.

So I do think there's a lot of social justice and equity arguments to be made on both sides. I totally understand that, but I do think that it is regressive in its application because we don't have Medicare beneficiaries pay back the cost of their benefits, and I do

think that the way we target Medicaid -- and setting aside all of the estate planning and the elder law attorneys and all, setting all of that aside, there's no need for any of that with Medicare. There's no need for that with Social Security. There's no need for that with federal pensions or other things. So why are we targeting this in Medicaid?

I recognize that that's not necessarily the right framework for MACPAC to make recommendations. So I will kind of honor the right framework, which is evidence based, and let's see what the administrative burden is.

I agree with Toby's last comment. If some states are less aggressive or less active in their enforcement, that doesn't mean they're not at risk for failing to enforce. It doesn't mean that they might not have a finding, OIG, federal OIG come along and recoupment for failing to apply the federal law. So I don't think that kind of like, you know, don't ask, don't tell out there is working, is a policy framework.

So I think that's kind of -- oh, there's one other comment I wanted to make as I look at my notes. The first time I was exposed to this on the Medicaid director side was when I was in New Mexico in the '90s, and it has

all kinds of crazy applications when you're talking about somebody who lives on sovereign Navajo property. It has all kinds of crazy cultural applications if you're talking about a Hispanic family that has a land grant from the federal government. There are intersections with cultural and sovereign pieces that are unique in some places that make the mandate at the state level unique in some places.

So I think I'll leave it there.

CHAIR BELLA: Peter?

COMMISSIONER SZILAGYI: Quick comment. By the way, I agree with Chuck in terms of our value statements completely, and I think this is really very charged.

I guess I have a question. How would we answer the first bullet? Is estate recovery having its intended effect? It feels to me like we're talking about maybe interviewing states and getting kind of a qualitative sense, but I'm not sure how we would really answer the first one. Whereas, I think we probably already know the answer to some of the others.

EXECUTIVE DIRECTOR SCHWARTZ: I mean, my thought on that, if we had some more information about who is the being effective, whose estates are being recovered, who

those people are, how big the estates are, where they are -- we could put more meat on the bones.

Ultimately, it's your assessment of that information, but what I'm hearing is that there's sort of hesitancy to do anything until we gather some more information, which seems legit.

And we didn't come -- I mean, Kristal made very clear in her presentation, didn't come bringing this all wrapped up in a bow.

COMMISSIONER SZILAGYI: Yeah. I mean, I think if the first bullet was something like what is the range and the scale and the spectrum of estate recovery and how does that vary across states, I think we can answer that. I'm just not sure what we would -- well, is it having its intended effect? What's the intended effect?

CHAIR BELLA: Yeah. I mean, I think it's a good question. It does get us more into the value social justice category.

I guess for me, when I called attention back to this, it's an ability for us to relook at this and understand. We'd have to have a baseline for what the effect was to begin with. That's a good point. But maybe

it's a question of is it time to just revisit sort of what the policy is achieving, maybe is a better way to think about that.

COMMISSIONER SZILAGYI: And I think we can address that.

CHAIR BELLA: Yeah.

COMMISSIONER SZILAGYI: Sort of if we just rephrase that, that first one.

CHAIR BELLA: Yeah.

I do think that's right that the general sentiment of the Commission seems to be interest in gathering more information.

There also does -- more than one person indicated there would be support for considering letting the state make this choice, and that we do have precedent for making this kind of -- doing that for states. So I want that to be reflected in the record as well, and that several heads are nodding.

Leanna?

COMMISSIONER GEORGE: I just wanted to comment that I feel, obviously, I think states should have the say in how they want to handle it, but I think we do need

federal safeguards or guidelines.

For instance, I'm not sure if my mom will ever need to be on Medicaid. We currently live with my mom in her house. She still works at least part-time most weeks. But my husband and I, we do most of the maintenance work on the house and stuff like that. The reason we do this is because of our kids. When Serenity, when she was living at home versus where she's at now, I couldn't work. I now spend a lot of my time doing advocacy work versus having a paying job that would help support the household and be able to have a house on our own.

So right now, I have the feeling that if something should suddenly happen to mom and I couldn't take care of her anymore because of her size and things like that, she would have to go into a facility because of her unique needs, we'll be homeless. If she was to pass away in the facility and they'd take the house, we would be homeless until we could find a location.

And that's why I'm saying I think not just for the minor children and surviving spouse and those who are disabled, but kind of spread out just a little bit further, to widen the safeguards that are currently there to take

into consideration those families that might be on Medicaid themselves or have children on Medicaid that rely on the support that they get from the family.

CHAIR BELLA: Thank you.

My only concern with collecting more information is that, as in several areas, what we hope to find may not be available or certainly not current or not at the level of detail we want.

So I think it would be great, Kristal, if you're able to go back and see, and then if what we're looking for isn't there, I don't want to just let this issue go away. We would want to revisit with any new information we have, and then if we don't have new information, have a discussion about the lack of information and where we might go. Kisha?

COMMISSIONER DAVIS: I agree with a lot of the comments, especially Chuck's comments.

I think for this issue, it would be really helpful to hear from states or beneficiaries who would be affected because I think there's not a lot of information out there, and so for this topic, I think it would be really helpful to hear from the folks who are dealing with

this issue.

CHAIR BELLA: Agree.

Any final comments?

COMMISSIONER BURWELL: In terms of collecting more data, I would touch base initially with NAMD. There used to be an eligibility committee, I think, if there's still an eligibility committee.

COMMISSIONER GORDON: Technical advisory committee.

COMMISSIONER BURWELL: Oh, the people who run the eligibility side, I think they'd be a good first place to start.

CHAIR BELLA: All right. Thank you very much. Thank you, Commissioners for the discussion.

We are coming up to the last topic of the day, which is countercyclical FMAP. Moira is going to present.

Just for a little context, in the guise of it's always good to address some things before you need them, kind of think about this topic in that vein, kind of thinking about we're not at a point of crisis right now. We're not in the middle of a recession, but should one be on the horizon or should one happen again, that it's nice

to be talking about this when we're not in dire straits. So that's a little context setting.

[Pause.]

POLICY AND DESIGN ISSUES FOR A COUNTERCYCLICAL FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP)

* MS. FORBES: Thanks, Melanie. Now I can see.

So, yes, as Jerry showed in the MACStats highlights this morning, Medicaid is a countercyclical program and it grows in program enrollment and spending -- goes up when there's a downturn in the economic cycle, and vice versa.

During the last two major recessions, Congress enacted stimulus packages that included additional Medicaid funding for states, which they did both to help support the additional demand for Medicaid and also to provide a mechanism for getting additional money into local economies quickly. In both instances, Congress increased the Federal Medical Assistance Percentage, the FMAP, which increased the share of Medicaid spending picked up by the federal government.

Various organizations have suggested that Congress could create a statutory mechanism to

automatically adjust the FMAP formula if certain economic conditions are met, and Congress also directed the Government Accountability Office, the GAO, to conduct an analysis of the effects of the increased FMAP after the last recession and provide recommendations for changes to the FMAP formula.

So this afternoon I will discuss some of the issues relating to a countercyclical FMAP. I will provide some quick background on the Federal Medical Assistance Percentage and Medicaid financing, talk about FMAP adjustments in response to the two prior recessions, quickly go over the design considerations and some other policy issues, and then turn it back to you for discussion.

I'm sure this is well-trodden ground for many of you. The federal share of Medicaid spending for most health care services is determined by the FMAP, which is determined annually by CMS. The FMAPs range between a statutory minimum of 50 percent and a maximum of 83 percent. This year, the highest FMAP for any state is 76.8 percent.

The formula used to determine each state's FMAP provides higher reimbursement to states with lower per

capita incomes relative to the national average, which is intended to reflect states' differing abilities to fund Medicaid from their own revenues. The formula also averages three years of data to minimize year-to-year fluctuations, which is helpful to states for planning purposes but also means that some of the data used in the calculation are fairly out of date.

Alternatives to per capita income have been suggested. It is a readily available measure but it doesn't correlate well with either states' abilities to fund Medicaid or with the demand for or the cost of Medicaid.

Medicaid enrollment and spending increase with the downturn of the economic cycle for a number of reasons, including a decrease in the number of employers who offer health benefits and an increase in the number of people who lost their jobs and lost their health insurance as a result. During and right after the 2001 and 2008 recessions, Medicaid enrollment grew about 8 percent each time.

States also have less revenue to pay for coverage during a recession due to decreases in sales and personal

and business income taxes, but generally can't run deficits or borrow to cover operating costs. So to pay for increasing Medicaid costs they either have to make cuts in other programs or make payment and service cuts in Medicaid.

The decreases in per capita income that happen during a recession don't have a big effect on the FMAPs right away because of how the formula is set up. First of all, because the formula compares each state's per capita income relative to the U.S. per capita income, if all the states are experiencing a recession, everyone sort of stays the same.

Also, the use of that three-year average means that older data is used. The per capita income amounts used to calculate the FY 2020 FMAP, were published in 2019 using data from the Department of Commerce that was available in September of 2018, and the data was from 2015, 2016, and 2017. So if there were a recession right now, we wouldn't see that drop in per capita income affect the FMAP until a couple of years from now.

As I said, during the last two major recessions, Congress enacted stimulus packages that included additional

FMAP, that helped pay for the additional demand for Medicaid, and directed federal funds into local economies quickly via provider payments. States didn't need to make any programmatic adjustments in order to access the additional federal funds because the federal share was increased when states claimed federal match for their expenditures. When they submitted their CMS-64, they simply received a higher share. They just got additional federal money for that.

The only requirement for states in order to access the funds was a maintenance of effort. They couldn't make eligibility more restrictive than it had been prior to the start of the recession, but they didn't have to file a state plan amendment or anything to get the additional FMAP.

However, Congress had to take action. The FMAP formula is in the Social Security Act, so a statutory change was needed. In both cases, stimulus funds were not available to the states until months after the recession began. So while states had asked for it and anticipated that some kind of federal stimulus would be available, they did have to make plans to make programmatic changes to deal

with the budget pressures.

So on to the design considerations. I am not asking the Commission to design a countercyclical FMAP, just walking through. You know, economists have thought about this a whole lot. I will just walk through a summary of some of the key factors that have been identified.

Creating an automatic FMAP that will go into effect under certain economic conditions requires a number of design decisions. There are multiple choices for each of these elements and every choice affects the timing and magnitude of changes in federal expenditures or the amount of stimulus money that would go to the states.

So I will go through them more on the following slides, but they include what economic indicators should be chosen to trigger an increase or signal the end of an increase, when it would start and end, what level of economic decline or improvement would trigger an FMAP change, whether an FMAP increase should be the same for all states or whether it should vary by state depending on some local factor, and whether it should be tied to some other program changes or requirements.

One of the problems that an automatic FMAP

increase is intended to address is timing. In the past two recessions, states experienced several quarters of economic contraction before Congress enacted the fiscal stimulus, which caused a lot of stress at the state level.

So the goal of an automatic FMAP increase are both to provide predictability -- states will know that additional federal money will be available if there is an economic downturn -- and to make the increase in the federal share available sooner. So you need a way to determine when an economic downturn is happening, and you need a measure that is timely, available, and ideally that corresponds to changes in state revenue and Medicaid enrollment.

Recessions are officially declared in the United States by a committee of experts at the National Bureau of Economic Research in Cambridge, which monitors the business cycle. If there are two or more consecutive quarters of decline in gross domestic product, which is a decline in the total value of all goods and services produced in the country, that is considered a recession, but that means you can't officially know that there is a recession until we have at least two quarters of data on all of the goods and

services produced in the country.

Other measures you can use to look at economic performance -- the regular FMAP is adjusted annually, based on changes in state per capita income, using data from the Department of Commerce that is at least a year old. But the Department of Commerce collects state-level data on per capita income on a quarterly basis, so more recent information is available if you wanted to use quarterly changes in per capita income as a potential trigger.

Other measures could include state domestic products, state sales tax collections, or unemployment. All of these measures have strengths and weaknesses. Some are reported more frequently, some correlate better to state conditions, and so on. They have all been discussed in the literature.

Again, since the goal is to make the increase in the federal share available automatically and earlier in a recession, one of the design decisions to make is what level of change in economic performance would trigger an automatic FMAP adjustment. There is a certain amount of fluctuation in the economy from quarter to quarters, as much as a percentage point in GDP up or down, which is why

a recession isn't declared until there are two consecutive quarters of decline at the national level.

For whichever measure or measures you have chosen, the magnitude, direction, and duration of the trend are all factors you would have to take into account. You also need to consider whether the threshold should be based on national or state-level conditions. In the past, Congress has made an across-the-board increase, but an automatic increase could be designed to apply when a state-level measure hits a certain threshold.

The design also needs to consider what level of change in economic performance would trigger it, return to a regular FMAP, and whether it would revert all at once or phase in over time.

Finally, Congress would need to decide what the FMAP increase would look like. In the 2001 stimulus bill, Congress provided a flat, across-the-board 2.95 percent increase for each state, and then the 2009 Recovery Act provided a flat 6.2 percent additional share plus an increased match to hold states harmless if they would experience a drop because of that per capita, compared to the national per capita part of the formula, plus an

additional increase in FMAP for states that had higher-than-average unemployment rates. So that 2009 had a local-state factor element to it.

Other factors to consider would be whether there should be a cap or upper bound on the maximum federal share a state could receive, whether there are any restrictions or strings to put on the funds, such as maintenance of effort provisions or reporting requirements.

Finally, there are a couple of other considerations that could be addressed. First is the treatment of FMAP for the adult expansion group, which already receives 90 percent FMAP. For states that cover this group, an additional FMAP could create a very high rate for this portion of enrollees, while for states that don't cover this group now, coverage at 90 percent FMAP is available through the state plan. So it provides an immediate countercyclical option that wasn't available during previous recessions.

The second issue is the treatment of CHIP. CHIP gets an enhanced FMAP or the E-FMAP, which is based on the Medicaid FMAP. It is higher. Congress has not raised the E-FMAP during prior recessions. Those additional percents

that I just mentioned were only applicable to the Medicaid FMAP.

Unlike Medicaid, which is open-ended in terms of federal match, CHIP has fixed annual allotments, and an FMAP increase would result in a faster drawdown of the CHIP allotment. However, if CHIP programs that function as a Medicaid expansion run out of their allotment during the year they have a couple of options, including reverting to open-ended Medicaid financing at the Medicaid FMAP rate.

Finally, I do want to mention that I think this is the first time the Commission has really discussed the FMAP per se. You know, there are concerns with the FMAP formula itself. GAO and others have identified shortcomings with the use of the per capita income measure, you know, using older data, and the countercyclical FMAP adjustment we are talking about here doesn't address any of that. Those are sort of separate issues.

So as Melanie said, we thought this was a good time to bring this up. This is not really an issue you can talk about when you are in the middle of a recession. It is not something that the Commission has talked about before.

One thing I should have mentioned earlier, a lot of this work was done by our intern, Cal Ernst, who couldn't be here today, but I did want to acknowledge since he is not with us. We did get a lot of support from our summer intern we get through the National Academy of Social Insurance. He is now a junior at Georgetown, so I just want to get Cal a shout-out.

But going forward, staff has taken on following up on this. So if there is further work you want to do, if there is a potential recommendation here, we can look into some things and bring it back. If you want to have us just develop this into a paper, we can just do that without, you know, taking a position on anything, or we can end things here. It is up to you.

But I would be happy to answer any questions, and I will turn it back to you.

CHAIR BELLA: Thank you, Moira and Cal. I will open it up to Commissioner comment, questions? Bill.

COMMISSIONER SCANLON: Okay. I didn't know today was going to be a trip down memory lane.

[Laughter.]

COMMISSIONER SCANLON: The first study I ever did

in health care was in 1975, and it was about the countercyclical aspect of Medicaid and the fact that the formula did not adjust. It was only about the problem and we didn't have any idea about solutions, so I can't be drawing sort of on that.

I think that, to me, sort of the two issues that might sort of facilitate finding a so-called remedy here would be to think about sort of the issue of timeliness and targeting, that you are going to generate more sort of support for something if you can identify that it is going to be more timely than our experience in the past, which is that we have waited for the problem to become so profound and then we have waited for the Congress to respond to that profound problem, that then we get a resolution. So there an issue of how one can do that.

And idea of some proxy measure other than sort of this lag sort of change in the FMAP is something we need to consider. The issue would be, sort of as if you started to think of alternative measures, how well would they work, in terms of being sort of earlier predictions of what is going to turn out to be a significant sort of problem.

Second issue in terms of targeting, and you

pointed it out, that there is variation across the states. I mean, we will have recessions and they are not going to be impacted sort of uniformly. And so what can one do about that? And that, again, sort of, I think it's an empirical question in part. So if we think about alternative measures then which ones would be sort of more effective in terms of targeting the money to where the problems are that aren't the most profound in the earlier stages of anything.

One idea I had, and this is kind of -- could be too pie in the sky -- is the issue of thinking about what adopting something that is similar to what happens with unemployment compensation, which is a process where, that when you go into a recession and you are paying out more in unemployment compensation, there is greater federal funding, but then there is payback sort of after the recession is over. So in some respects the states sort of borrow and then pay back.

And that may not be a permanent sort of thing that you want, that, you know, this is the only thing we're going to do, but it could be something -- think of it as an early-stage response, that if a state is experiencing sort

of a situation where it meets certain criteria in terms of measured need, that it could opt for some advanced funding on the condition that when that experience sort of changes and they have a better economy that they will sort of pay some of that back.

I mean, I realize that right now we are in good times. States are building surpluses. So it is not that they always are operating just at the break-even level. They have variation too. And so I think from a federal perspective there might be sort of more openness to quick responses if they knew that they were not necessarily sort of permanent contributions.

CHAIR BELLA: Thank you. Toby?

COMMISSIONER DOUGLAS: So I think this is great that we are talking about this in advance. I was just thinking, as many of us are talking about trips down memory lane, and we had Andy Schneider here earlier, there is such a turnover on both sides, I think it would be really good to have an issue paper, if this were to happen, that it would be, you know, this is our role to be informing Congress, not necessarily with a one-set approach, but at least laying out the options for giving the congressional

staffers -- many have changed -- that there is an easy ability to react and have the information. So that is number one.

I do think, you know, part of this problem is that years into the FMAP, because, Bill, as you talk about the incentives, this kind of gets into the inherent problem with the FMAP. And maybe we do structure this around just addressing the approaches to deal with downturns, but then it does get into, you know, issues around back to what we talked about this morning, on how to get in front of any discussions on block grants or financial incentives or awards across the state and the federal government, because it brings in that too.

Regardless, I think this is a great issue paper.

CHAIR BELLA: Kit?

COMMISSIONER GORTON: So I agree with Toby. I think it's a great issue paper. And I, at least, am not familiar with the scenario that Bill described, going, I guess, back to the beginning of the program, which is you get a downturn and then stuff goes sideways, and then you've got to wait for Congress to act.

So I think it would be useful if only to have

everybody have the same backgrounds, to summarize, this is what happens. Recessions will come, and here has been the pattern in Medicaid when a recession comes. And obviously more recent data might be somewhat more interesting. But to the extent that, you know, there have been three, four, five recessions in the life of the program, major kinds of things in the life of the program, if we can say, okay, 50 years of Medicaid, here is what happens when the country goes into a recession, or when a major region goes into a recession. Here are the impacts.

And it would seem to me that that tees up, then, the work to say, well, okay, now that we know what happens, how do we mitigate that in some way? What's the remediation, and how timely does it have to be? When does the bad stuff start to happen? How much time do you have? I think that would inform when you would kick it in and how deep does it have to be. Does the historical record suggest to us that there are big recessions and small recessions, and the small recessions are less impactful on Medicaid than the big recessions? Or maybe small recessions are equally impactful as big recessions.

I think it would be useful, to the extent that we

can draw together that data, to then inform whatever it is that we are going to do to recommend remediation.

CHAIR BELLA: Tom, and then Bill.

COMMISSIONER BARKER: I was just going to echo what Toby and now Kit said. I think it would be a great resource to have available for when the next recession comes, so that Congress could turn quickly to it and then have a respected source for information.

CHAIR BELLA: Bill?

COMMISSIONER SCANLON: I would just offer, and if we start to think about sort of looking at the FMAP more broadly, I mean, I'm going to give you sort of the GAO perspective on this, which they did a lot of work on. And is that, if you really think about what you want to include, it would be a measure of what a state's need is, and then, secondly, a measure of what a state's capacity is. And if you think on the need side, that is a combination of the size of the population that is going to need services as well as the cost of delivering the care to those individuals.

And, in particular, sort of the driver on the population side is the number of poor people, the low-

income people that are in a state, their demographic distribution. If you've got sort of disproportionately senior population, they are going to need more LTSS, that makes it a whole lot more expensive. We all know that the cost of care varies tremendous across the areas, and so that is a big factor.

Per capita income is not maybe the ideal measure of state capacity to pay but it is not necessarily sort of a bad one. But when GAO has put these things together in formulas, the redistribution effects would be profound, because it is a very, very big difference in terms of the populations that are served across states, in mean, in terms of the share of a population that is low-income, and the share of that low-income population that is either senior or disabled. And so that is one thing that makes a very big difference in terms of having a discussion about how we might want to change the FMAP.

CHAIR BELLA: I think that is why we are dipping our toe in with countercyclical before we get in a funding fight. It reminds of you DSH, huh, a little bit.

Other comments?

So I think you are hearing interest in pursuing

certain some -- I think that's a first step perhaps, a resource document maybe, for lack of a better word. But I actually think that, while we're doing that, alongside that I think we could be teeing up the next level of discussion, because it does seem like there is interest in doing so. Would folks agree with that.

Moira, do you have enough from us to know which direction to go there?

MS. FORBES: Yes.

CHAIR BELLA: And so timing-wise, what does that look like, do you think?

MS. FORBES: To bring something back? I'm working on TPL, so I'll talk to Anne.

CHAIR BELLA: I didn't mean to put you on the spot. Do you have any comments, Anne?

EXECUTIVE DIRECTOR SCHWARTZ: Yeah, I was just going to say, you know, Kristal will get back to state recovery after she solves the dual problem.

[Laughter.]

EXECUTIVE DIRECTOR SCHWARTZ: Yeah. We will see how many things we can do all at once.

CHAIR BELLA: You are just seeing a lot of like

the appetite for lots of things today, so thank you for putting all that.

We are going to turn to the public now for any comments, either on this subject or on a state recovery, which we talked about prior to this.

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: Hearing no comments, Moira, thank you. We are done with the business for the day. We start our public meeting tomorrow at 9 a.m., and we will be starting with a session on the Medicaid savings program.

Thank you all.

* [Whereupon, at 3:53 p.m., the meeting was adjourned, to reconvene at 9:00 a.m. on Friday, December 13, 2019.]

PUBLIC MEETING

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

Friday, December 13, 2019
9:01 a.m.

COMMISSIONERS PRESENT:

MELANIE BELLA, MBA, Chair
CHARLES MILLIGAN, JD, MPH, Vice Chair
TRICIA BROOKS, MBA
BRIAN BURWELL
MARTHA CARTER, DHSc, MBA, APRN, CNM
FREDERICK CERISE, MD, MPH
KISHA DAVIS, MD, MPH
TOBY DOUGLAS, MPP, MPH
LEANNA GEORGE
DARIN GORDON
CHRISTOPHER GORTON, MD, MHSA
STACEY LAMPKIN, FSA, MAAA, MPA
SHELDON RETCHIN, MD, MSPH
WILLIAM SCANLON, PhD
PETER SZILAGYI, MD, MPH
KATHERINE WENO, DDS, JD

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[9:01 a.m.]

CHAIR BELLA: Good morning. We are going to get started with a session on the Medicare Savings Programs. I will turn it to you, Kate and Kirstin.

IMPROVING PARTICIPATION IN THE MEDICARE SAVINGS PROGRAMS: POLICY OPTIONS

* MS. BLOM: Thank you, Melanie. Good morning, everybody. So today Kate and I are going to be talking about the Medicare Savings Programs, or the MSPs. The MSPs, as you know, are administered by states, and they help beneficiaries pay for their Medicare out-of-pocket costs.

We're talking about them today because we have found that many people who are eligible for these programs do not actually enroll, and policymakers are looking to find ways to change that. In September, we heard from Tim Engelhardt, who is director of MMCO, about their efforts in this area.

Our plan for today is to review coverage for duals at a high level, including what beneficiaries pay for their Medicare costs. We'll talk about the MSPs, who's

eligible, the benefits that the MSPs provide, and then we'll review how many people are enrolled and the share that that represents of all eligible beneficiaries. Because enrollment has historically been pretty low, we'll describe factors that might be contributing to that and then discuss potential policy options to address that for you all to consider.

As you know, duals receive health care coverage through both Medicare and Medicaid. The two programs cover some of the same services, such as physician services, and where that's the case, Medicare is the primary payer. Although in Medicaid beneficiaries have nominal out-of-pocket costs, Medicare beneficiaries pay premiums and cost sharing, especially if they choose to enroll in Part B, which is the medical insurance component of Medicare.

Part A is a little bit different since most people don't pay premiums for Part A, which is the hospital insurance component, because they have a work history. On this slide you'll see we've only shown Part B and Part A. You'll see the different costs for each. They can be quite high, especially in Part A, if you don't for some reason qualify for premium-free. We have not included Part D on

here because beneficiaries receive assistance with Part D out-of-pocket costs through another program called the Medicare Prescription Drug Low-Income Subsidy program, or LIS.

There are four separate Medicare Savings Programs that provide different types of assistance and have different eligibility criteria. They're commonly known by their acronyms, so people just refer to them as the QMB, SLMB, QI, or QDWI programs.

Each has different income and asset eligibility criteria and covers different types of Medicare out-of-pocket costs, some of which is shown here. I've tried to keep this slide simple so asset limits, for example, are not on here. But you can see generally QMB goes up to 100 percent and then sort of ticks up from there.

Some people are not eligible for full Medicaid benefits because they don't meet the Medicaid eligibility criteria in their state, but they're still eligible for the MSPs. They are called partial benefit dually eligible beneficiaries to reflect their Medicaid benefit status. The QMB and SLMB programs offer coverage to both. The other two programs only offer coverage to partial duals,

and partial duals only get their premiums covered. They don't have the deductibles and co-payment coverage that the full duals get.

A couple quick things about the QI and QDWI. QI was designed to not increase costs to states, so it's fully funded, so it's 100 percent FMAP. And QDWI is kind of a unique MSP in that it is only for people who have lost premium-free Part A coverage because they've gone back to work. So the QDWI program is actually a very small program.

Also, just for context, about 28 percent of duals are partial duals. Their only interaction with the Medicaid program would occur through the MSPs, so enrolling them in the MSPs might be particularly difficult because if they're not already familiar with the MSPs, they would have no contact with Medicaid. They'd have no reason to touch base with Medicaid.

Finally, on this slide just to note for context for you for later that the LIS program, which I mentioned before, which provides Part D coverage, subsidized coverage, their eligibility level is at 150 percent, which is slightly higher than the QI level, which ends at 135.

But this will be useful later to remember when Kate talks about alignment with Part D LIS as a potential policy option.

Just a quick look at enrollments in the MSPs. As I mentioned, or I think I mentioned, QMB is the biggest program with 7.8 million people in it and, again, sort of ticks down from there. QDWI is very small, although it has grown since last time we looked at this, from around 200 to around 500 people. But this is 2018 Medicare data, just to give you a sense of how many people we're talking about here.

In 2016, we did a study with the Urban Institute to look at participation in these programs to try to quantify across the MSPs how many people were actually enrolling, and we found that for the two largest MSPs, the QMB and SLMB programs, only about 51 percent of eligible enrollees actually enrolled in the programs, and that was using 2009 and '10 data from the Survey of Income and Program Participation, or SIPP.

Enrollment, as I said, has been historically low. Other studies have found results that are similar to ours, and so as a result, the Congress has enacted a couple of

legislative changes to try to address this. The Medicare Improvements for Patients and Providers Act of 2008 required the Social Security Administration, which administers the LIS program that Kate will talk about later, to begin transferring application information from LIS beneficiaries to states so that states could then initiate an MSP application for a person who is likely in a very similar situation and would likely be eligible for the MSPs.

That, of course, was intended to increase enrollment, and GAO did do a study a couple years after that legislation went into effect and found about 5 percent increases in enrollment in those years. There were other factors, of course, that might have impacted enrollment, including other MIPPA provisions such as increased outreach funding for states. That outreach funding continues to be available and has been reauthorized every year since then.

So, with that, I'm going to turn it over to Kate. She's going to talk about the factors that are affecting enrollment in the MSPs and potential policy options for you all to consider to address those.

* MS. KIRCHGRABER: Thanks, Kirstin.

So the key enrollment factors that we're highlighting are related to outreach, the application, and eligibility redetermination processes. Individuals have to apply for the MSPs with their state Medicaid program, and like anyone applying for Medicaid, they have to provide documentation to verify their eligibility. States are required to redetermine MSP eligibility at least once every 12 months, and in some states that can mean submitting a brand-new application. But states have flexibility to simplify the process. And while they serve similar populations, as Kirstin mentioned, the MSPs operate differently from the Part D LIS. LIS is administered by the Social Security Administration, and the Social Security Administration automatically contacts and enrolls many eligible individuals.

States, on the other hand, administer the MSPs, and they develop their own outreach and enrollment processes, which generally don't include automatic enrollment.

There is some federal funding for outreach to increase awareness of the MSPs. There are grants available to the State Health Insurance Assistance Programs, or

what's known as the SHIPs, for Area Agencies on Aging and for Aging and Disability Resource Centers. That has mostly been flat funded over the years at about in the $20 to $25 million range across all three of those programs, and that has been steady since about 2008.

So there's a number of policy options that we could talk about to help increase enrollment in the MSPs. We'll start by talking about better alignment with the Part D low-income subsidy.

As Kirstin mentioned, there's already a structure in place to transfer data from the LIS applications to the states. The states, on the other hand, though they may not be able to take advantage of the data transfer because they may count income, assets, or family size differently when they're looking at eligibility for the MSPs, and that means that they end up reverifying a lot of the data that gets sent to them by SSA. And we know from a GAO study from 2012 that at least 35 states reverified the data that they got from SSA. And for beneficiaries, that can be really confusing. To have to provide additional verification or data can be burdensome as well.

So if states were to align income and asset

disregards or family size policies with LIS, they could more easily use the SSA data to determine eligibility for the MSPs. It would likely increase MSP enrollment, but it would also increase state costs.

Another option would be to expand MSP eligibility levels to 150 percent of poverty, which is the upper limit for the low-income subsidy program. This would increase the number of individuals eligible for payment of the Part B premium. It would allow beneficiaries to apply only once for both LIS and the MSPs.

MedPAC has actually recommended this in the past, and they made the point in their recommendation that it would provide more targeted financial assistance to low-income beneficiaries than doing something like increasing payment to plans or providers. This option also wouldn't increase state spending since QI is fully federally funded. There wouldn't be a state cost to that.

Another option would be to streamline the eligibility redetermination process. Dually eligible beneficiaries typically don't have big fluctuations in their income that would make them ineligible for Medicaid, so states could use approaches like passive or ex parte

recertification or send pre-populated forms to beneficiaries to simplify the process. There's only a handful of states, literally like four or five, that do this now. But we do know that approaches that involve little, if any, input from the beneficiary reduces the chances that they're going to get dropped upon renewal for failure to submit paperwork. This would be particularly helpful for beneficiaries whose circumstances haven't changed. They'd avoid just having to send something back saying, "My circumstances haven't changed." It would increase state costs, and there's a chance that passive reenrollment could renew some individuals who are no longer eligible.

Another option is to improve outreach either by increasing spending or by encouraging states to improve the notices that they send to beneficiaries for the MSPs. A lot of potential beneficiaries may not know that they're eligible or where or how to apply for the programs, and this would especially be true probably for partial-benefit duals who don't otherwise have contact with the Medicaid program.

We could also look at creating incentives for

states to enroll partial-benefit duals since enrolling them is just a cost to the states. And it's also an administrative burden since states don't, as we said, generally have contact with these Medicare beneficiaries otherwise, because the only Medicaid that they qualify for is the payment to help them with their cost sharing. And so they would have to conduct targeted outreach to find these beneficiaries. So we could do something like offer states an enhanced FMAP that would reduce their financial disincentives to enroll partial-benefit duals. It would increase federal spending, but it wouldn't cost the states.

And, finally, while we can't necessarily recommend this because it would require a change in the Medicare statute, we could discuss federalizing the MSPs or having Medicare assume the cost for the MSPs. This is often discussed as a way to improve the program, and it would allow the Social Security Administration to enroll people in the MSPs and LIS at the same time. And if we decide to pursue other options that we've been talking about, we could have a discussion of this in whatever, whether we write a chapter or just a paper, and kind of stop short of making a recommendation, but we can

definitely discuss the issue.

We're happy to discuss and further develop any of these options, or if there are things we haven't thought of that you want to talk about, we're happy to discuss those. So thank you.

CHAIR BELLA: Thank you. That was a nice way of breaking down a very complicated subject, so thank you.

Darin, do you want to start?

COMMISSIONER GORDON: Yes, thank you. That's very helpful. I'll preface my question with I strongly believe in reverification and think it's important. It's a necessary step and it is currently required.

I would say we would think oftentimes about there are certain populations where there's just not enough volatility in their circumstances, just that it begs the question that they should be on a different cycle. So when I saw this about you have to reapply for MSPs every 12 months, I was just curious. Do we have any information or have a sense that those who fail reverification, you know, what the volatility is there? Is it just purely not responding to the reverification forms? Or is there actually a change in circumstance? And the reason I say

that is because we may want to think about this is one of those populations I would just suspect doesn't change very frequently, that we really rethink, you know, or at least have a discussion, potentially a recommendation, on whether or not a 12-month reverification for this particular program makes sense. Or is it just busy work?

MS. BLOM: What we have heard is that it's not -- there are not many changes, that generally the reason for dropping off is an issue with paperwork. And so it's actually -- it just creates a gap in their coverage because they end up coming right back on once that gets resolved.

CHAIR BELLA: Chuck.

VICE CHAIR MILLIGAN: As I am getting my notes ready, thank you for the presentation. I do think that there's a lot of value in working toward aligning the LIS programs with the MSP programs.

There is in most states an existing process to receive Social Security files for purposes of SSI eligibility for Medicaid that states incorporate and accept as kind of an eligibility determination of disability and poverty status. So I do think, you know, there is -- like the roads have been paved already in certain ways, so I'm

supportive of kind of continuing to work in this vein around how to do better alignment to increase the take-up rate of the people who are eligible for MSP programs but unenrolled.

There's a couple of other elements of the distinction I just want to mention because of the kind of lack of alignment in some ways between MSP and LIS. One is the way that D-SNPs do supplemental benefit planning ties often to LIS status, not MSP status, in terms of what benefits can be offered or targeted, is maybe a better way to say it, targeted to people in a D-SNP. You can target based on LIS status. You can't target based on MSP status. And that targeting can be very helpful to deliver benefits to people who don't qualify for full Medicaid but need additional supports. And we can kind of get deeper into that over the course of the work plan in this area.

The second is, you know, we've talked in the past about look-alikes, D-SNP look-alikes, and MedPAC has certainly talked about look-alikes in the past. One of the factors that people typically look to to determine is a given plan a look-alike is whether the Part D premium obligation is below LIS. And if it is, because ultimately

you have a premium that you're not ever charging people because it's getting picked up by LIS, it's one criteria by which people say, yeah, that's a look-alike.

So I do think that getting deeper in the work toward helping people who are eligible but unenrolled get enrolled, using the road that's already paved with Social Security files going to state Medicaid agencies for SSI purposes, to Darin's point, there isn't a lot of kind of volatility in this eligibility. So I do think there's less kind of risk of improper payments and other things. And I think that getting tighter alignment between LIS and MSP programs also helps drive broader alignment generally around things like D-SNP benefit planning, D-SNP integration with Medicaid, and D-SNP look-alike identification.

So I think I'll kind of leave it there, but thank you for helping drive the work here. It's really helpful.

CHAIR BELLA: Kit.

COMMISSIONER GORTON: So two things. I appreciate Tim and Melanie's -- and respect and acknowledge their perspective that MSP is an important set of programs. I remain confused about -- I have a tiered confusion about

why it is, particularly for the partials, but even for the full-benefit duals, why it is that there's a state role here. Right? I mean, we talk about the Medicaid-ization of everything. This is essentially the Medicaid-ization of Medicare. And, you know, the Medicare people have lots and lots of resources. They have their own MedPAC. And I'm sort of wondering why, if we think -- if MACPAC thinks that there's a legitimate state role and purpose here, then I think we would help ourselves and everybody else in trying to state what that is. And if we can't articulate that somewhat crisply, then I think it raises the question -- it just raises the question of is there a state role or should there be a state role.

And that leads me to my second observation. We have developed a theme over the course of the last two, three years with respect to our program efficiency work, where we say if something from a Medicaid perspective is administratively burdensome, somewhat resource-intensive, which increasing enrollment outreach would certainly be, and has a modest or minimal value add, you know, we felt free -- even yesterday we were doing this -- to sort of throw a flag on the play and say, you know, just what are

we doing here.

And so the other thing I think that would be useful is to get beyond anecdotal reports and qualitative assessments of the state level of effort and the value to the state. I'm not suggesting that the beneficiaries don't need somebody to help them take advantage of this subsidy to access their Medicare benefit. I just think we need to look at the administrative piece of that. And, you know, the cynic in me says, well, you know, this is just one small way to get states to pick up some of the cost. And, you know, states are perfectly happy to federalize a whole bunch of other stuff, so it's not that I'm suggesting that that's unfair. But it's just -- if we want a clean, efficient, understandable, comprehensible, beneficiary-friendly program, then some of these hand-offs maybe could be eliminated.

CHAIR BELLA: Brian and then Bill.

COMMISSIONER BURWELL: I am by no way an expert in this, but the things I have read, it seems to me that the estimates of the number of people who are eligible and not enrolled have generally come from simulations or analyses that these are the number of people who should be

eligible based on their income, blah-blah-blah, and these are the number of people who say they're enrolled. And it's only half.

But I think there's a paucity of data on the eligible but not enrolled population specifically, and do they have alternative sources of coverage for these benefits, or why haven't they applied for to be partial duals?

The little that I have read seemed to indicate that there is quite a high percentage that do have alternative coverage. They're either retirees that have their retirement health care benefits provide these services, or they have Medicare supplemental plans, or they're in Medicare Advantage plans that provide similar benefits. I mean, how many truly are out there who are eligible but have no coverage for Medicare cost sharing?

EXECUTIVE DIRECTOR SCHWARTZ: So I guess my question is I don't know how we would get at that. It took us two years to complete this study to link the enrollment data with the SIPP. So, I mean, I appreciate the question, but I just -- I'm not sure how we can shed light on that. So do you have --

COMMISSIONER BURWELL: No, my comment more is everybody is like developing policy options for fixing this problem, but I think there's just a paucity of data about why is it that there are so many people who are potentially eligible but not enrolled.

CHAIR BELLA: Bill?

COMMISSIONER SCANLON: Well, to Brian's last point, I mean, I think that we do have data that show that people with Medicare supplemental plans, that for the people close to poverty, it's the lowest percentage of them that have them. As your income goes up, you're more likely to have one of these plans, but they're not inexpensive. So there's that.

I mean, there certainly are people that are here that are eligible for these programs that are going to have other coverage, but I think that we have to be concerned about the ones that are not going to be eligible for other coverage or be able to afford other coverage. How big that group is, I mean, I think it's significant enough that we need to worry about, and there may be sources like the Medicare Current Beneficiary Survey that can give us some information about that.

I want to go back to sort of what Kit was talking about, I had the same kind of feeling, which is why isn't this program uniform and the administration streamlined.

Chuck, when you talked about transferring the Social Security files to the states, I was thinking to myself, why aren't we transferring the decision to the states that this person is eligible? So that would be sort of one step because if you've gone through the process -- when the states are reviewing these, what's the value-added of their review? I mean, what are they looking at that would be different than what Social Security looked at? If there is something there, then we should certainly be thinking about that.

CHAIR BELLA: Well, I think it just says -- stop there for a second. It's because they have different income and asset requirements, right?

MS. KIRCHGRABER: Or family size is another.

COMMISSIONER SCANLON: Well, but the issue is sort of -- I mean, we've got standards for this in terms of poverty levels. Why is that acceptable to have that in terms of we've set up a program where we've set some poverty standards, and then we say, "Well, it's up to them,

interpretation of what that standard really means." I think that's a question to be considered.

Where I am going to say I sort of disagree with you is I don't think it's a change to Medicare or it's an incorporation of this into Medicare if there was to be federalization of this.

I don't know exactly what the boundaries are of Medicare, but to me, the unique things about Medicare are how the money -- how it's financed, where the money is coming from. Part A is coming primarily from payroll taxes and the Trust Fund, and Part B is coming from a combination of premiums and general revenues.

Federal government does all kinds of things out of general revenues, and they could set up a program. It doesn't have to be part of Title 18. It doesn't have to be part of Title 19. It could be a separate sort of title where they say, "We're going to spend some of our general revenues on a program to pay for cost sharing on behalf of sort of lower-income individuals."

Again, I feel like we're not changing Medicare at all. We're not changing the benefit structure. We're not changing the financing. What we're doing is we're saying

this particular cost-sharing subsidy would be something that becomes a federal responsibility and is federally administered.

CHAIR BELLA: Chuck?

VICE CHAIR MILLIGAN: Two quick things.

I want to align myself with Bill and Kit with what you're saying.

There is an example of moving toward a uniform national model, which is MAGI, coming out of the Affordable Care Act, the calculation of income, household size, all of that. So I do think there is a recent example that we can turn to.

One quick comment, I hope quick comment, Kit, going back to your point. There is an area where somebody who is a QMB, SLMB, the state might want to have something to do with it still, but the state can do that.

Here's the example. If somebody qualifies for Medicaid long-term services and supports, like an HCBS waiver-type eligibility, the income level is higher. It's often like 220 percent of the federal poverty level, typically. But the state can still subject that person to the state income and asset, LTSS kind of eligibility

criteria if they want to then become a full-benefit dual by virtue of qualifying for a waiver slot-type thing. That to me is completely consistent with having a uniform approach for MSP-, LIS-type programs.

CHAIR BELLA: I just have like three questions, and then Martha, and then I'll make a few comments.

Have we heard from states on this? Have we had a chance to talk with states about this in the past?

MS. BLOM: No, not really, but that is on our -- if this is an area we want to keep going, that is something we've wanted to do.

CHAIR BELLA: Okay. So second question is -- I know this is not as straightforward as it seems, but theoretically, we could look at where all of the states are today and the difference in their countable income and assets and family size relative to what it would be if we recommended alignment with LIS, and we would understand how many states that would be an increase for, right?

Okay. Have we done that work, or could we think about doing that work? It feels to me it would be helpful if we're thinking about promoting alignment with LIS. We need to understand what that delta is with existing states

today.

MS. KIRCHGRABER: Yeah. I mean, we could definitely look at it. We're just getting started on this work and wanted to get a sense of where you're interested in us doing more work.

CHAIR BELLA: I also think it's sometimes -- I don't know that every state, it's clearly defined and easy to find ways. I think that's been a challenge in the past.

Third question is, when we've had the information about eligible but not enrolled, do we have that as a state level, or is that national?

MS. BLOM: We have that from the Urban Study at a state level, although some states, the size was too small to publish. So we have that internally.

CHAIR BELLA: And do you happen to remember if there were like a handful of states that were like glaringly -- I mean, I'm trying to figure out is this a uniform problem, or are there some states that are close to 90 or 100 percent, and we would learn from what they're doing? We'd be able to say, "Yeah, they're doing ex parte," or whatever they're doing. And maybe that's just something we could look into to see if there's any patterns

and differences where we see bigger gaps than others.

MS. BLOM: Yeah, we can look into that.

CHAIR BELLA: Martha?

COMMISSIONER CARTER: Yeah. Just to bring this down to the practice level for a second, I was administrator of a community health center, which by definition served a high proportion of low-income people. It was clear that there were people who were Medicare beneficiaries who would have qualified for an MSP but were not enrolled. The problem seemed to me that there was no clear assistance for them, and it's a fairly complicated program. As you said, people who weren't already interacting with the Medicaid program may not have any way to know that they even qualify.

So it took some outreach on our part -- and I know other health centers do this -- to try to bring that information to their patients.

But I think there's not enough resources, maybe not enough clear accountability for outreach and getting these folks who are eligible enrolled in these programs.

CHAIR BELLA: Any other Commissioners?

[No response.]

CHAIR BELLA: All right. I think you're hearing there's interest in -- so, obviously, there's this issue of state-federal role. It is sort of comical that we have a Medicare savings program that Medicaid runs.

But I think coming out of this, what you're hearing is interest in getting a better understanding of what is the state burden and kind of the state process and our theme of administration and bandwidth and efficiency and all that kind of stuff.

There is interest, I think, in pursuing LIS alignment with a little bit better understanding of what that would mean, and the what that would mean then, I think, would support whether we'd want to talk down the road about trying to push for partial FMAP increases to help support. I that's a big lift, it might -- obviously, there seems to be interest in still talking about federalization or the right balance between the state-federal role. If we are to push for more standardization, whether that's with LIS or in a different way, then like where does this most appropriately live to help economically and efficiency and access and all of those things?

So those are sort of the key things I hear coming out of this in addition to just the general interest. So I think, certainly, if we can be moving in the direction of having recommendations that we could include in June, which I assume means coming back to us in January or April or something with more of this information, I would say that's something it appears to me that we would welcome. I know I personally would welcome that.

Any other comments?

And I know we have time for public comment after the next session, but I'll go ahead and ask for public comment on this particular subject right now as well.

PUBLIC COMMENT

* MS. FRIED: Hello. My name is Leslie Fried. I'm from the National Council on Aging, and we actually are a MIPPA resource center. So we have funding to provide technical assistance and training to the state, SHIP, AAAs, and ADRCs who do a lot of the outreach and enrollment. So I have just a few quick comments.

We actually track the states that have adopted flexibility, either eliminating the asset test or increasing the income standards for Medicare savings

programs. It's on our website. We're more than happy to share it. So it has every state that's done that.

What we find regarding outreach and enrollment, we actually are in the process of doing some research, trying to get at that number as well. There's not really good data sources on the asset test. That is a huge problem, trying to figure out the modeling, because the asset test is a big problem.

Part of MIPPA, Social Security every year around late May, they actually send letters to people they think may be eligible for an MSP or LIS but not enrolled. So they send these letters across the country, several million, and saying basically, "Based on our data, you may be eligible for these programs, and this is how you apply." And they usually refer to the SHIP programs to get more information.

The issue is -- and we get a lot of calls and emails at the end of May and early June from the SHIP programs because people aren't asset -- it's the asset test. So if you're thinking about recommendation, the asset test is a huge problem because it includes any little bit of -- you know, a retirement account is included and

all the alignment problems you heard about, extra help, but we find that if someone just has like $10,000, which is supposed to last 30 years, the rest of their lives, or $15,000, they are not eligible for these really important programs.

Even though they may -- people generally can't afford Medigap programs. They're really expensive, and even if they did a little bit, the Medigap programs do not cover Part B, as in "boy," premium. And the importance of MSP is you're also deemed eligible for extra help.

The one other point I want to make is that you might look at SNAP. SNAP actually has for some of the elderly, they have these ESAP -- they're called Elderly Simplified Application Projects, but they allow -- states have the opportunity to have three-year certification periods because this is a population whose income isn't going to change. So their situation is very similar to the older people who are applying for MSP. So you might look at that as a consideration.

Thank you.

CHAIR BELLA: Very helpful. Thank you.

Toby?

COMMISSIONER DOUGLAS: On this point, on the asset test, it really does go back to what Chuck said on MAGI but from a different perspective. As from a Medicaid policy precedent, all eligibility for Medicaid for when you look at it, it's not streamlined to exclude the asset test. So why would these programs that are, in essence, on the medical, not for long term services and supports, have it? So I think there is a precedent to eliminate it here as well.

CHAIR BELLA: Brian?

COMMISSIONER BURWELL: I think that's a very important observation in terms of a barrier to increasing enrollment. I was just wondering if there has been any previous legislative attempt to actually do this. Has it come up as a policy option? Has it ever been considered? Because it seems to be a relatively straightforward fix.

EXECUTIVE DIRECTOR SCHWARTZ: I can't speak to that, but I can speak to a number of years ago, probably when none of you were on the Commission. We had this very discussion here about now that we've dealt with MAGI for one part of the program, what do you think about for the other populations? And there was absolutely no willingness

at that time.

It's an interesting observation in the life cycle of a Commission like this. So, if you guys want to go there, the staff can do the work to support you in that.

CHAIR BELLA: While we are looking at background and legwork, let's add that to the list and also look at SNAP.

Other comments from the public?

[No response.]

CHAIR BELLA: Other comments from Commissioners?

[No response.]

CHAIR BELLA: Do you guys have what you need, or do you have any last questions for us?

MS. KIRCHGRABER: I think we have what we need.

CHAIR BELLA: Okay. Thank you very much.

Continuing with our integrated care seam from meeting to meeting, we are going to talk about barriers to integrated care this morning. Kristal and Kirstin, take it away.

BARRIERS TO INTEGRATING CARE FOR DUALLY ELIGIBLE BENEFICIARIES: POLICY OPTIONS

* MS. BLOM: Thank you. So as Melanie said, we are

here to talk about barriers in integrating care for duals. We just want to do a quick review of where we are on integrated care in this meeting cycle. We are working on these three policy questions: For state are integrating care, what strategies could result in greater integration? What pathways are available to states that have not yet pursued integrated care, taking into account their individual circumstances? And then what factors present barriers to state integration efforts, which is our focus today?

We have also been hearing from experts recently on integrated care efforts, so just to remind you, in September we heard from a panel of federal and state officials, including MMCO, and then two states, Washington and Idaho, talking about the efforts that they had underway around integrating care. And then in October we heard from a beneficiary advocate, provider, and health plan about their work in this area.

Also, going back to last year, 2018, we did hear from Arizona and Virginia about their efforts at that time on integrated care, and they just -- just as a little preview to what Kristal is going to talk about -- they did

talk a lot about the importance of Medicare expertise in their efforts as a barrier to what they were working on.

So for today we will be discussing barriers, as we said. We have grouped these barriers into two main buckets: enrollment challenges and then limited capacity in Medicare, and we developed policy options for you all to consider that are aimed at addressing those. I will be talking about the enrollment challenges and then Kristal will talk about Medicare capacity.

So we have grouped enrollment challenges into a couple areas. First is automatically or passively enrolling eligible individuals into these programs, the different guidelines in Medicare and Medicaid, and the issues that those create, and then the role of private brokers, brokers that are working for plans in directing duals into non-integrated products.

Around passive enrollments, getting and keeping people who are eligible enrolled in these programs has been an ongoing challenge. The primary vehicles that states have, and MA plans have, are passive enrollments into the financial alignment demonstrations and then default enrollment into D-SNP plans.

This first bullet is maybe best understood as an issue of default enrollment, which is used to enroll people, Medicaid beneficiaries, into an MA plan when they first become eligible for Medicare under the same parent company.

A second issue is around, well, policy option is around passively enrolling people who have previously opted out of passive enrollment. This is something that is currently prohibited in CMS guidance, and that prohibition continues for the life of each state's demonstration. The Commission could consider thinking about a change to that guidance, or suggesting a change to that guidance to allow people who have previously opted out to be eligible for passive enrollment again in a future contract year.

There are pros and cons to these. I think, you know, they would be seen as increasing enrollments, which we have heard potentially from other panelists, but then we have also heard from other panelists about concerns around automatic enrollment for these beneficiaries, that it limits their opportunity to make choices.

So a second option that we could think about is the special enrollment period. Enrollment has been lower

than expected in the duals demonstrations, and health plans have had some difficulty managing an arrangement in which duals can switch plans at any time during the calendar year, as permitted under Medicare.

So in April of last year, CMS published a final rule to narrow the special enrollment period for dually eligible beneficiaries to move from an open-ended monthly enrollment period to one that is only used a few times a year. But although that change was intended to keep dually eligible beneficiaries in integrated products for longer, such as in the duals demonstrations, all of the demonstration states opted out of that change. There were concerns that the narrower SEP was preventing people, or would prevent people from opting in at any time. And, of course, given the low levels of enrollment that many states are facing you can understand that that was a concern for them.

So an option would be to modify this to keep it narrow but allow the opt-ins to occur at any time. Again, arguments for this would be increasing state adoption of the narrower SEP, which could then reduce plan switching, which has raised concerns around continuity of care and how

it might impact that negatively. Arguments against could just include administrative burden on states and plans to now have people opting in at any time of the year.

Currently, open enrollment periods in the two programs, in Medicare and Medicaid, are not aligned. Medicare Advantage has a standard period but Medicaid, of course, differs by state and sometimes by population. So dually eligible beneficiaries seeking to enroll for coverage in both programs are going to have to do that at different times. Medicare's period normally occurs -- open enrollment period normally occurs from October to December, and then starting in 2019, Medicare Advantage has a new open enrollment period from January to March. But in states there are different enrollment periods for different populations, such as the newly eligible group or dually eligible beneficiaries, and some states, such as Minnesota, have decided to align for duals specifically with Medicare Advantage.

The Commission could encourage or require states to consider aligning Medicaid open enrollment periods for the dual population with the Medicare Advantage timelines. To the extent that this is an administrative burden on

states, the Commission can consider an incentive of a higher FMAP for those expenses.

This could lead to less confusion for beneficiaries and a more streamlined process for enrolling in both programs. It would also decrease flexibility for states in that they would not be able to now set their own standards to meet their own circumstances. It could also lead to admin burden around like changing beneficiary materials, perhaps changing systems. So those are some things to keep in mind.

The rule of enrollment brokers in steering beneficiaries toward or away from integrated products is another factor that might be a barrier to integration but is not very well documented. There has been a lot of concern among policymakers that private or plan brokers might have incentives to steer people away from an integrated product where a non-integrated product is available and has a higher payment rate.

State Medicaid programs typically contract with an independent broker, who is just there to provide assistance in selecting a plan, but this is different from Medicare Advantage, where MA plans rely pretty heavily on

enrollment brokers to market their plans and bring in potentially eligible people, and they receive compensation for doing so. Direct marketing like that is not permitted by most Medicaid managed care programs.

So under an integrated model, brokers with state contracts might not be familiar with MA products, and as a result they might have difficulty providing good advice to beneficiaries about Medicare options, whereas private brokers working for MA plans obviously have all of the Medicare expertise and would be able to assist people from Medicaid coming into Medicare in selecting a product.

There are also some issues around compensation. States might not be familiar with the rules around compensation. A lot of these rules appear to be pretty state-specific. So the Commission could consider asking CMS to clarify the role of brokers, including when compensation is permitted, and then may want to consider, as a way of discouraging enrollment in non-integrated products, something like a penalty for brokers who do so when an integrated product is available in that plan's market area. This is something we would need to do more research on, to the extent that there is interest in this,

in terms of how a penalty would be imposed or who would be imposing it.

And I should have said this earlier. All of these options are things that are ideas that we have but we would definitely need to go down these roads more deeply, to the extent that you guys are interested.

All right. That I am going to turn it over to Kristal to talk about challenges around limited state capacity on Medicare.

* DR. VARDAMAN: So integrating care for dually eligible beneficiaries requires states to have expertise in Medicare for tasks such as designing programs and for developing D-SNP contracts. This expertise is required not just at program launch but it is also needed on an ongoing basis.

Technical assistance is available from CMS and through the Integrated Care Resource Center, but states might not fully utilize those resources or they may just not be enough in terms of it being a sufficient substitute for having actual in-house expertise. In fact, state officials have emphasized to the Commission the importance of such in-house Medicare expertise.

In the October 2018 panel, that Kirstin mentioned, Tom Betlach, then Medicaid director in Arizona, and Karen Kimsey, now Medicaid director in Virginia, both noted that they have staff assigned to Medicare work such as developing D-SNP contracts. Director Kimsey also noted that Virginia defined this as a priority need and noted that not every state has the same level of support from its administration and legislature to do this, in terms of assigning the resources that it takes to make that happen.

Given limited funding and competing priorities, we have heard from a variety of stakeholders that this is a barrier for states' integrated care efforts.

So to address this issue, a policy option could be to consider a grant program for the development of state expertise that would further integrated care efforts. For example, the Commission could recommend that Congress authorize funds for a program that would enable states to fund Medicare-focused physicians or to develop existing staff, and that could be for states that are new to integrated care or also those that are looking to enhance their existing integrated care programs.

So states would submit a plan and proposed budget

regarding their intended use of award funds to CMS for its review and approval. And this could be modeled after the approach used the in Financial Alignment Initiative, where CMS grants funds to support up-front costs and infrastructure for states designing new delivery of payment models.

So as we turn to your discussion we are interested in your feedback on these policy options. We will return in January with another presentation on those two other policy questions, so there will be an additional opportunity to discuss some additional policy actions then. And we are working toward a June chapter, so we will continue to be returning to you each month to refine the policy questions and move towards developing draft recommendations.

Thank you.

CHAIR BELLA: Kit.

COMMISSIONER GORTON: So thanks for the ongoing work. It is, as you all know, very important.

Just two quick things. You talked about broker steerage to or away from more integrated models. I don't think that is complete without talking about provider

participation and provider steerage, and that is a complex nut because if you are health plan then there are considerations for writing network architecture which will cause you, in terms of maintaining an economically viable price point for your network, to choose to contract or not contract with providers.

Providers, similarly, evaluate their practices from a business perspective to say, what is the insurance payer mix that I can accommodate in my practice in order to meet the financial targets that I aspire to for my practice? Like laying aside the issue of whether you think the financial targets that the providers set for themselves are right, that is up to them. Participation in our programs is generally voluntary. There is some effort on the part of states to sort of force people into various things, but particularly in the managed care aspects, states have trouble strong-arming people into the managed care programs.

And so I think there is this complex dynamic with respect to providers, particularly in less densely populated regions. You know, you may not have enough providers to afford people reasonable choices. The

provider community may actually not exist in some places. And this gets back to what we talked about, I think, at the last meeting, of giving everybody an option for integrated care. I think that there are many communities in the country where an integrated care option isn't even available and couldn't be constructed for love or money.

So, you know, I do think we need to highlight the issue of provider participation and then, in the last piece of this that I participated in directly, the Financial Alignment Initiative in Massachusetts, we saw very active provider steerage away from participating in managed care. And the backdrop is that in the Medicare fee-for-service program you can choose anybody you want, and that, I don't think, is going to change. So, you know, I think we need to keep that in mind.

And then the other piece, there is a deeper question, and in my mind this is analogous -- you know, I trained in pediatrics, and for the entirety of my professional life over the last X decades the pediatric and family practice communities have been trying -- internal medicine -- have been trying, I think with very mixed success, to convince the American consumer population that

primary care, as envisioned by the primary care specialists, is a good thing and they should participate in it. And there are some people who buy that for a little period of time while their kids are young and getting shots, but, you know, I don't know that we've sold the American people on primary care.

And so I think analogous to that, I think there is a fundamental issue. I don't think we have sold the American people on the benefits of integrated care, and I don't know whose job it is to articulate that and sell it, and it may be a very hard sell, given our experience with primary care. But I think that needs to be flagged as a barrier as well. So it may not be available in your community, your preferred providers may not be interested in participating in it, and we may not have convinced you that you really should integrate your care for many reasons, whether it is stigma from substance abuse or HIV or whatever else.

So I think those are important background contexts. They shouldn't stop us from addressing the addressable stuff that you all have laid out, but I do think that if we are going to be writing chapters about

things that they are worthy of mention.

CHAIR BELLA: Darin.

COMMISSIONER GORDON: Two points I want to make. One on the enrollment side. I think we've just got to be careful. Some of the comments Kit was making, understand that you are seeing different results in different markets, with regard to enrollment and integrated products. So there are some lessons to be learned. So there are some good models where you have seen very large participation and stickiness, and then there are others who have very low participation and stickiness. And I think we talked about this at a prior meeting. You know, particularly like on the MMPs, and some of the information you guys have provided us, there was stark contrast between Ohio versus the others, so there are lessons to be learned there, and that is one model. And then you look at the alignment approach, D-SNP alignment approaches in Tennessee and Arizona, and those were higher still.

So I think there are some lessons to be teased out there, to make progress in that regard, not changing any of Kit's comments but just maybe a footnote there.

With regards to the Medicare expertise, and

talking with a lot of states that one does come up quite frequently, I think another consideration we should make, particularly, you know, if we look at the integrated approach where, you know, it is a commonly held understanding that Medicare benefits through these strategies, that either a higher match rate for those positions, which is not uncommon -- we do this in a variety of other areas, IT and clinical expertise.

But in this case I'd even maybe make the pitch that it would be 100 percent funded, given that if you have this expertise and you are moving toward an integrated strategy, it will benefit the federal government, 100 percent. And hopefully through some MMPs there's some savings that comes back to the state, but some of the alignment approaches that have been coming back to the state is less clear. And in any of those scenarios Medicare, I think, typically benefits the most.

So just another one of those options, thinking about that barrier, because I really do believe if you really look at the tip of the spear, the thing that is stopping progress is having someone that understands the programs to even begin going down the path of considering

different approaches to integration.

CHAIR BELLA: Brian, then Toby, then Tricia.

COMMISSIONER BURWELL: I think there are huge opportunities to align enrollment and integrated care products with general initiatives around enrollment in HCBS or LTSS programs. Many states are -- you know, for people whose parents are beginning to need LTSS supports, the process of trying to figure out where I can go to get support is very complex and difficult. What are they eligible for, et cetera.

And a large number of states are trying to improve the efficiency by which people learn about LTSS supports, apply for services, apply for the waiver program, get in, go through the necessary. And that initiative is generally referred to as the No Wrong Door initiative, where no matter where someone enters the system initially, and it could be a AAA, it could be anywhere, not necessarily Medicaid, they are given information about what the requirements are and what the application process is.

And in those states that are MLTSS states, those initiatives often include if you apply for a waiver you will then be asked to choose an MLTSS plan to receive those

services. And in most MLTSS states, the Medicaid plans are aligned with a Medicare plan.

So there is a lot of communication and benefits counseling that goes on in regard to getting people into HCBS waiver programs, and the choice of electing an integrated care product, and it may not just be a -- you know, and include things like PACE. Like we have PACE programs in the state and you can go to PACE too. I just think that there, as a general approach to increasing enrollment in integrated care products, there should be better communication and alignment between what we think of as Medicaid and general enrollment process into HCBS programs, and there's communication. Because it is an ACL initiative, I think they should be brought into the conversation.

CHAIR BELLA: Thank you.

Toby?

COMMISSIONER DOUGLAS: So a question on the passive enrollment, which I continue to believe is a large barrier, but it's always there's value judgment around the value of integration versus the value of choice.

Is there anything more analytical we can do? When the question of the Commission proposing -- it is the recommendation to encourage or require passive enrollment, what more can we learn, or is it really at this point just this value of what we think is more important?

MS. BLOM: I mean, we can definitely do more research and maybe talk to more people. In terms of data, I'm not sure there's a lot more to look at there. We've definitely heard -- we heard in our last panel from the advocacy side in particular, they have strong feelings about this. Others disagree.

I think we've seen evidence that it does -- when it's used, it leads to higher enrollment, but that's sort of what we've got.

COMMISSIONER DOUGLAS: Yeah. I mean, I would say -- and I think Melanie's -- I mean, from that, I very much respect that advocate, but it has to be colored with the intricacies of the California environment, and what she was explaining was -- again, it would be -- if we were to do it, we'd need to put that in context of what was going in California, both county by county, factors, provider factors, as well as the way it was implemented in

California along with long term services and supports.

I mean, I guess those are things that we would do, but it's good -- I mean, I just want to say again I think this is an area that aligns with Medicaid of enrollment into managed care. If we can't do more analysis, I think this Commission just needs to figure out what's the value and really encourage if we want to explore integration.

Especially as more states are moving probably to D-SNP, we can't touch the default enrollment on the D-SNP, go to Medicare rules, but we could use this as a learning to inform what Medicare does on that side.

CHAIR BELLA: Tricia?

COMMISSIONER BROOKS: So my question or comment is also on passive enrollment.

Certainly, I know from the consumer beneficiary perspective that there's definitely hesitations around passive enrollment because of how states may choose to do it.

So, when I look at this Slide 5 and it talks about enrolling individuals who are already enrolled in Medicare Advantage Plans into a product of the same parent

company, I think that makes -- it has some logic to it. But I'm just curious whether we actually know. Is that a rule that that's the only way we can do passive enrollment, or can we use other algorithms? Do we know more about that? And if we don't, in our research, that might be something that we probe a little bit more to better understand the states that are engaging in passive enrollment as well as are people then switching plans or opting out after they get passively enrolled, having some of that data? And I think that would be hard to get on a 50-state basis, but certainly looking at a handful of states, it might be informative.

CHAIR BELLA: Chuck?

VICE CHAIR MILLIGAN: Thanks.

Excuse me. I'm going to echo a couple of things that have been said. When I think of the major barriers to further integration, I go back to just in some states, the difficulty of doing managed Medicaid with dual eligibles in LTSS as a political and operational capacity. So there's just a gatekeeping with some states not being able to kind of crack that nut. I don't think we have a role to play necessarily in that.

I do think that the complexity in the Medicare expertise is a barrier. I kind of align myself with what you said, and Darin and many others have commented as well.

I do think that part of the challenge to integration is the fact that the majority of dual eligibles are still in Medicare fee-for-service. Comments have been made in this session around provider kind of steerage and the provider implications of all of that.

I know that CMS is working to try to promote managed care within Medicare. Again, I don't know kind of how we crack that nut. I think the default enrollment helps, but the Medicare fee-for-service is still huge. The majority of folks are there.

The two that I haven't heard today that I do want to just make sure we don't lose off of our list, one is a comment I've made several times in several meetings. It's difficult to get -- to meet the geo-access or network adequacy standards for a D-SNP in parts of the state, any state, where you have Medicaid managed care for dual eligibles. So you can have counties that for Medicaid purposes meet the provider geo-access standards but not for Medicare purposes. So what that means is in those

counties, you can't get to integration because the only real available option is Medicare fee-for-service.

So I do think that one of the integration challenges continues to be the varying definitions of network adequacy and geo-access to get geographic alignments, that you can have programmatic alignment.

Then the last one I want to mention is how states utilize their MIPPA agreements to try to drive alignment in terms of a comment that Darin has made around -- you know, one barrier is that if the initial savings go to the Medicare program, what's the state incentive financially? There are some tools with how states use their MIPPA. There are tools of how states use their MIPPA requirements and integration and design, the kind of rules of engagement piece of this, that I don't think we should lose sight of.

I know that ICRC has done some good work on this. I think we need to kind of keep with that work too.

CHAIR BELLA: Any other Commissioner comments?

[No response.]

CHAIR BELLA: I kind of want to go through the things that you laid out and talk about what I think I've heard and then address the areas that we haven't talked

about.

So, in the first one, in passive -- or automatic enrollment, I think we have default enrollments. We have ongoing passive enrollment into the demonstrations, and then we have passive enrollment of people who have opted out in the past. There may even be a fourth group, but I think those are very different things.

I don't agree, Toby, that we can't touch default enrollment. State Medicaid agency has a significant role in default enrollment in making sure that data are getting where they need to be getting for the plans to be able to identify the people who are eligible for default enrollment, and without the state approval, they can't do default enrollment, regardless of CMS. So I think it's fair game for us to talk about it. We may not be able to fully recommend, but I think it's important for us to keep on the list, particularly as more states are moving toward lining up the two plans. That's going to be a really important tool.

On the ongoing passive, my understanding is a majority of states that are left in the demonstrations are doing ongoing passive, which means the newly eligible

people are coming in, and they're put into the demonstration as they come in. It would be worth checking, and it would be worth understanding is that the case, and what are we saying with retention rates? If somebody is not doing it and it appears to be effective in the other states, why aren't they doing it? With the exception of New York. I think we all know why New York is not doing it since that's winding down.

On the folks who have opted out, I know several -- not several -- some states are asking for that ability to try passive again, with the argument that they may have received a notice six years ago and a lot of things have changed. And there have been program improvements.

I guess it feels to me that the piece of information I don't have is has the state done a lot of outreach to suggest that this is an option to them and make sure that they understand what those benefits are so people would have a choice, now the fifth or sixth year. So I'm curious what they're doing on the outreach side. I think before, we would jump right to say that you could try passive enrollment again, because a lot has changed, and being able to point that out and having some positive word

of mouth might be helpful. So kind of keep that on the list, but it would be interesting to learn that.

On the second, which was narrowing the special enrollment period, nobody spoke about that. I take that as there's not any concern with that. I mean, it seems like something that if the state wants to do that and the state -- the whole point is to allow people to make a choice into an integrated program, and so if there's a barrier to allowing them to make that choice, it seems consistent with where this Commission is to remove those barriers and to allow, then, to make that exception in that special election period.

On aligning, we also didn't talk about the recommendation to align Medicaid and Medicare. I'd be curious what some states think. My guess is the states would be reluctant and concerned. It would be helpful to understand why it's been so successful in Minnesota, for example.

I also think -- and this is worth checking. I think Minnesota actually enrolls their beneficiaries into the Medicare plan, and that beneficiary doesn't have to go through the plan, which helps then as the state has aligned

the enrollment periods. They're also aligning the actual enrollment, and I think that would be worth understanding. I think they almost function like a TPA on behalf of Medicare, and that helps with the enrollment. So it would be worth understanding if there's a little bit more than just aligning up the days.

On the broker issue, you all know how I feel about the broker issue. CMS has received a lot of comments about brokers in the context of a lookalike. It would be worth looking at what some of those are. They range from applying penalties. It also ranges to not allowing brokers to receive commission on duals, period, which is beyond the purview of MACPAC. But as we think about that, I think that the challenge is just making sure we wouldn't advocate some sort of penalty that would somehow create an unintended effect that disadvantages integrated products, which is the situation we find ourselves in, in some states today, I think.

On the support for states, for the majority of states that received the million dollars in the Financial Alignment Demonstrations, it was pretty effective. That million dollars went a long way, and when you think about a

program where we're spending $350 billion or sort of in that magnitude, that seems like a pretty non-material investment to make, particularly, probably, all states wouldn't take it up.

So whether it's a million dollars or whether it's enhanced FMAP, I think I'm hearing support for that, and I just want to add my own support for that.

I would say, though, it is very important that we think about bandwidth for the states in supporting state capacity, but the states that do this well, also, they have a really strong relationship with the state and the consumer advocacy community. And there's not a lot of support for on-the-ground consumer advocacy support.

I think about Massachusetts. If you think about the combination of my favorite advocate, Dennis and Corey at the state, like that's super powerful. So as we think about supporting integration, not forgetting that there's a way to also provide support, I think, to build consumer advocacy to partner with the state, it seems to be something worth thinking about.

Then I would just add Chuck's reminder about MIPPA. I think and that -- MIPPA applies to all three of

the policy questions in terms of what states are using, states that are doing it, states that are not doing it, and barriers to doing it.

Then my grand finale comment is it did come up in the last session that the number one barrier to all of this is that we have two titles, and so all of these things we are addressing do not actually get at the heart of the biggest barrier, which is we're still doing all of these things within operating in two separate worlds.

I know MACPAC can't recommend a brand-new title, but just so that it's in the record, I want to express that that is and remains a barrier for us to think about, as perhaps three Commissions from now we'll be able to take that up, looking into the future.

Any other comments from Commissioners before we turn to the public?

Toby?

COMMISSIONER DOUGLAS: Just on this point, I just want to echo kind of what you were saying. Some of the other policy options where there's special enrollment really get to this question of administrative capacity of states. So while they're good ideas, I think it really

gets to what can be done and figuring out approaches that really streamline. So, as you said, I was reading more into what staff were saying about the default enrollment on the D-SNP side.

To the extent we can really put that on, if you couple that with changes on the brokers, of paying brokers for duals, then you can have kind of taking the unintended consequence on both sides, passive enrollment plus taking the brokers out of that without creating a new administrative requirement on the states.

CHAIR BELLA: Any other comments from Commissioners?

[No response.]

CHAIR BELLA: Do we have any public comment?

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: Do you both have what you need from us? Any areas of clarity?

MS. BLOM: No, I think we're good. That was a very helpful discussion.

CHAIR BELLA: Okay. We will take a break. We will restart at 10:30. Thank you.

* [Recess.]

CHAIR BELLA: All right. If we can reconvene, please?

Welcome, Martha. We are turning to maternity care and Medicaid's role.

MEDICAID'S ROLE IN FINANCING MATERNITY CARE

* MS. HEBERLEIN: Thank you, Melanie. So as discussed at the October meeting, staff are coming to the Commission with a series of analyses to inform a descriptive chapter in the June report that will lay out the issues affecting maternal health among Medicaid beneficiaries as well as document approaches that CMS and states are taking to improve outcomes in Medicaid. Today I will present the next piece of that work, which focuses on Medicaid's role in financing maternal health.

So working with our survey data contractor, the State Health Access Data Assistance Center, at the University of Minnesota, this analysis uses CDC, or Centers for Disease Control and Prevention, natality data to better understand the number of births covered by Medicaid, the characteristics of these women, as well as where these births occur and which providers attend them. So before I

get to the data findings, I'm going to provide a brief review of our prior work and preview what will come next.

So as a quick reminder, the work laid out for this year builds upon MACPAC's June 2013 chapter. This foundational chapter provided an overview of Medicaid and CHIP's role in providing maternity care services, including the eligibility pathways for pregnant women, the benefits provided, the changes under the Affordable Care Act, and state and federal initiatives to improve outcomes.

In November 2018, MACPAC published an issue brief looking at access and outcomes for pregnant women in Medicaid in comparison to other payers. Then in April, we released an update on the information in the foundational chapter that focused on state payment initiatives to improve Medicaid outcomes. And in October, you will recall we had a panel discussion on the federal initiatives to improve maternal outcomes featuring findings from the Strong Start for Mothers and Newborns Initiative as well as the current administration's focus on rural health and substance use disorders.

So following today's presentation, we will be back after the first of the year to examine maternal

morbidity and substance use disorders as well as a panel discussion highlighting states' approaches to improving maternal health.

So looking at Medicaid's role in maternal health, highlighting this area as one of importance to the program. Overall, Medicaid paid for 43 percent of all births in 2018. While private coverage paid for just under half, fewer births were uninsured or paid by another payer.

The share of births covered by Medicaid varies across the states, ranging from about 25 percent in North Dakota to 63 percent in Louisiana and Mississippi. Medicaid paid for more than half of all births in six states -- Arizona, Louisiana, Mississippi, New Mexico, Oklahoma, and Tennessee. Commissioners, you have a state-level table in your appendix that shows births by state and payer.

A greater share of births occurring in rural areas, among young women under the age of 19, and women with lower levels of educational attainment were paid for by Medicaid. Medicaid was also the payer for a greater share of births among Hispanic, African American, and American Indians and Alaska Natives. Given its

disproportionate role in covering these births, Medicaid could play a key role in improving outcomes and health disparities among women of color and in rural areas.

So shifting slightly to look at the characteristics of mothers whose births are covered by Medicaid, which will help us better understand who the women are, their risk factors, and potential areas for improvements in terms of access and outcomes. So beginning with demographics, most mothers whose births were covered by Medicaid are between the ages of 20 and 34. More than half of Medicaid-covered births were among white, non-Hispanic women. While Medicaid for a larger share of births in rural areas compared to other payers, as I just discussed, the majority of Medicaid-financed births occurred in urban areas.

In comparing mothers in rural and urban areas with Medicaid coverage, a greater percentage of rural mothers were younger than 20, and a greater proportion were white, non-Hispanic. Conversely, a greater proportion of women living in urban areas whose births were paid by Medicaid were Hispanic or black, non-Hispanic.

Two-thirds of mothers covered by Medicaid had a

prior birth with about 6 percent having a prior preterm birth and 25 percent having a prior C-section delivery. One percent of women covered by Medicaid had pre-pregnancy diabetes and 2 percent had pre-pregnancy hypertension.

In addition, more than half of women whose births were paid for by Medicaid were either overweight or obese, and almost 15 percent smoked cigarettes prior to pregnancy. The share of women with potential complicating health conditions was similar across rural and urban areas for those covered by Medicaid. An exception was cigarette smoking, which was more prevalent in rural areas.

Almost all births financed by Medicaid occurred in a hospital setting. This did not vary much by state, with most states having less than 1 percent of Medicaid births occurring outside of a hospital. However, in Alaska, slightly more than 4 percent of births occurred in freestanding birth centers. While more than 90 percent of Medicaid-financed births were attended by a doctor, there was considerable variation across the states. In 23 states, more than 10 percent of births were attended by a certified nurse midwife, with approximately 30 percent of births attended by a certified nurse midwife in Alaska and

New Mexico. Place of birth and attendant did not differ when looking at women in rural and urban areas who were covered by Medicaid.

Over two-thirds of women or about 68 percent of women whose births were financed by Medicaid started prenatal care during the first trimester, and more than three-quarters of women received nine or more prenatal care visits over the course of their pregnancy. However, there was considerable variation across states, with just over half of women in the District of Columbia beginning prenatal care in the first trimester and about 55 percent receiving at least nine prenatal care visits. In contrast, in Vermont 85 percent of women began their prenatal care in the first trimester and almost 90 received nine or more prenatal care visits. Women in rural and urban areas with Medicaid did not differ on these access measures.

Finally, looking at outcomes, almost one-third of women covered by Medicaid delivered their infants via caesarean section ranging from about 20 percent in Alaska to 37 percent in Mississippi. Eleven percent of infants born to Medicaid-covered women were preterm, delivered prior to 37 weeks, and about 10 percent were low

birthweight, weighing less than 2,500 grams. The rate of preterm birth was highest in Mississippi and lowest in Vermont, and the rate of low birthweight infants was highest in the District of Columbia and lowest in Alaska, California, and Utah.

So that was a lot of numbers, and I went through them pretty quickly, but hopefully this provides some context for the presentations that will come as well as the June chapter.

So, with that, I look forward to your discussion and am happy to try to answer any questions you have.

CHAIR BELLA: Martha. Thank you, Martha, thank you, this Martha. Questions to this Martha.

COMMISSIONER CARTER: Thanks, Martha.

MS. HEBERLEIN: Thank you, Martha.

[Laughter.]

COMMISSIONER CARTER: Do not kill the messenger here. Why do we not have a measure of maternal mortality on this list? And it's not your fault, obviously. It's not reported. It's not something that we routinely collect. It's not a routine measure for a national quality form. It's not a routine measure for HEDIS, I don't

believe. I understand that, you know, it's relatively low numbers. Every maternal mortality, of course, is a tragedy, but there are 700-some across the country. You know, you do get into some numbers problem, but, still, we're not reporting it. So what's up with that?

MS. HEBERLEIN: So we have been trying, and I am still trying, to work with the CDC that collects the mortality data, and 700 is low, and then by payer -- there were changes to the birth certificate in 2003, and it took states a while to sort of all come on board with those changes to a more uniform birth certificate. And so the payer data is not available until 2016, so that's part of the problem.

And so I've been trying to see if we can get even, you know, several years of data merged, if we can -- we're not going to be able to look at it by demographics and Medicaid coverage, but at least to get some sort of sense, you know, is Medicaid a greater share -- are Medicaid-funded births a greater share of those or a lesser share, and trying to figure out something. So we're still working on that, and, you know, I wouldn't hold your breath, but -- I'm not going to say I'm hopeful either.

I'm still working on that.

COMMISSIONER CARTER: And the other part of that is it's my understanding that all states don't define maternal mortality the same way, especially after delivery, like in the first year postpartum. Is that accurate?

MS. HEBERLEIN: I think there have been some efforts to try to make that more standard as well as to collect information about pregnancy on the death certificate. But I think then linking that death certificate with the birth certificate to figure out if that birth was paid for by Medicaid is more complicated. And I think that whether or not a woman was pregnant in the last year does not necessarily mean that her death was related to that pregnancy, right? She could have been hit by a bus or something else. I mean, it's horrible to say, but there's all sorts of factors that could go into it. So I think it's more complicated than just having a linked death certificate with a birth certificate that was paid for by Medicaid. So I think it's --

COMMISSIONER CARTER: Yeah, I think the issues may be around maternal suicide and maternal drug overdose, which can be related to the pregnancy. So, anyhow, I think

it's a complex issue, and thank you for giving us this baseline information. But I wanted to call out that, you know, we're really not measuring one of the main factors that we care about.

CHAIR BELLA: Tricia, then Leanna.

COMMISSIONER BROOKS: So I agree with you, Martha, but I'm excited to see this data. The last time or the most recent data I'm aware of in terms of the percent of births paid for by Medicaid is 2013.

I'm just curious how much of this data are we going to actually publish on a 50-state basis, because I think all of it would be of interest.

MS. HEBERLEIN: I don't think that decision has been made yet. I think at least by payer would definitely be in the chapter. But I think, you know, if there's interest in publishing state-level data, I don't see why we can't include more of it.

CHAIR BELLA: Leanna.

COMMISSIONER GEORGE: I was curious primarily with the 19-year-olds, how many of them possibly had Medicaid prior to becoming pregnant? And how is their access to birth control to prevent the pregnancies of these

young individuals?

MS. HEBERLEIN: The data we have, it's birth certificate data, so it says who was the payer for that birth. We did do a look at using linked survey data with the birth certificate to figure out a little bit more on the prenatal care because that survey asked, Who paid for your prenatal care? So I can look back at that to see about the age break and how many of -- it still doesn't quite get to your question about how many of those younger women were already enrolled in Medicaid or CHIP prior to becoming mothers, but I can see what I can find on that.

CHAIR BELLA: And then the second part of her question, how comprehensive do we know about access to contraceptive benefit, family planning waivers?

MS. HEBERLEIN: That's not on the birth certificate data.

CHAIR BELLA: Right. I just mean generally.

MS. HEBERLEIN: But, yes, I can look more. There's been a lot of studies that have looked at access to different types of contraceptive, whether it's through a family planning waiver or through Medicaid, and we can pull some of that stuff together if you guys are interested.

CHAIR BELLA: Thank you. Stacey, then Toby, then Peter.

COMMISSIONER LAMPKIN: So, Martha, you said it's a lot of numbers, and it is a lot of numbers, especially given the extra detail that you're letting us see here. And I think it's a tremendous contribution. The state-level variation is fascinating in these tables and very valuable to understand, so I would just encourage us, as much as we feel like it's reliable and sharable, we should share the state-level variation. So thank you.

CHAIR BELLA: Toby?

COMMISSIONER DOUGLAS: I think I know the answer, but I wanted to know the intersection between Medicaid eligibility and when their prenatal visit -- given it's a linkage, do we know kind of were they on Medicaid before they started their prenatal visits? Was that the trigger? Just understanding what, who -- you know, and this gets to the question of what are the levers we have to start prenatal care earlier through Medicaid or more public health.

MS. HEBERLEIN: Yeah, so when we did that PRAMS work, which was the brief that compared outcomes across

payers, that is the data source that includes a survey component as well as the birth certificate data. And what we found is that, you know, 38 percent of women had Medicaid coverage for prenatal care and about 28 percent had coverage prior, in the month prior, Medicaid coverage in the month prior. What we didn't do is track particular women to see whether or not their coverage source changes, but there are other studies that have used this data source that have looked at churning among pregnant women, so we can dig in a little bit more with those studies as well as, you know, maybe rerunning some of these data to provide a better answer of if they were on Medicaid before, what did their prenatal care look like, because we didn't break it down quite like that. But that's something we could look at.

COMMISSIONER DOUGLAS: Okay. And then the other, just moving from fee-for-service into managed care, is there any -- just to understand any barriers or improvements that occur during that transition?

MS. HEBERLEIN: I haven't seen -- but I can look at that more, at least not from the data we have here.

COMMISSIONER DOUGLAS: Is there anecdotally,

managed care plans, you know, the challenge that they get, they don't get on to managed care until the second or third trimester. And so is that a barrier or not? Or have they been getting enough care within the fee-for-service?

CHAIR BELLA: Peter.

COMMISSIONER SZILAGYI: Thanks. This is -- I support doing work in this area, and I think this descriptive data is really, really important. And I agree with Stacey's comment about the variations across states.

I don't know the CDC natality data set as well. Does it have information on use of other services during pregnancy since -- I mean, we've done a lot of these studies. Forty percent of low-income women have postnatal depression; half of that was prenatal depression that was triggered, if you actually really study this population closely. So use of services or access to services would be useful, but I just don't know the CDC natality data set at all.

MS. HEBERLEIN: So these data do not have that because it is really just lifted from the data that are supplied on the birth certificate. But I could look back. There are additional questions on the PRAMS survey that I

mentioned before that we didn't pull for that initial issue brief that may include access and use of other services. So we can look at that some more.

COMMISSIONER SZILAGYI: One other very quick point. I like the way the tables are formatted. It may be interesting just potentially in text to flip the percentage, the row and column percentages by race and ethnicity, to say out of all African American populations, Latino populations, what percentage are covered by Medicaid? In other words, flipping it around.

MS. HEBERLEIN: That's the first table, so, yes, it's -- so the first table in your -- so we looked at it two ways. We looked at it among women with different characteristics, what was the share of them that was covered by a particular payer, and so that's Table 2-1 or -- is it 2-1? Sorry, Table 1. So if you look at the table, there's 516,000 or so --

COMMISSIONER SZILAGYI: Okay. Thanks.

MS. HEBERLEIN: So we did it that way, and then when I talked about the characteristics of the Medicaid -- so the tables in your appendix focus more on just the Medicaid population as opposed to the demographics across.

CHAIR BELLA: Toby, then Fred. Shoot, sorry. Darin. Sorry.

COMMISSIONER GORDON: So disappointing. So disappointing. I thought we almost made it finally through one meeting. Here coming up against the clock, and she gets it in there. That's awesome.

Just a comment. You and I have talked about this before, but a little bit around your confidence around the number of prenatal visits, because what we had found is that global payment models actually underreported prenatal visits. So I'm not sure where that information is coming from and whether or not that could or couldn't -- wouldn't be a factor.

MS. HEBERLEIN: Yes, so that's reported by the facility on the birth certificate, so it's not reported by the pregnant woman herself. So, you know, I can look at it a little bit more in terms of whether, you know, it's an EHR type linkage where then, you know, they might actually have some sort of record of it versus, you know, some other sort of piece. But yes, your point about the bundled payments and is it an episode of like care, you know, it's definitely probably underreported in those cases.

CHAIR BELLA: Fred.

COMMISSIONER CERISE: Thanks, Martha. It's good information. I think it's definitely something we should be looking at.

First, real quick, there was a comment at the very end where you referenced MACPAC work and said that compared to insured women, women with Medicaid were more likely to have C-sections. I don't know if you can say anything more about that or if we know anything about the outcomes of that or anything behind that.

MS. HEBERLEIN: I can't. I can speculate. Uninsured includes women who are self-pay. You know, there's very few of them. I think it is like 4 percent of all births. And if you look at uninsured women, you know, they have higher rates of home births and freestanding birth center births. So, you know, like that could also be playing a role into, you know, those women may be at a lower risk, they may be opting for a different type of birth than other women. So, you know, I think there is a lot there that we don't know.

COMMISSIONER CERISE: It could be good. It could be bad. We don't know.

MS. HEBERLEIN: Yeah.

COMMISSIONER CERISE: Do you know which states -- we'll have the discussion now about trying to address the, what is it, the fourth trimester, you know, covering for that year of postpartum. Are there any states that are doing that now, and what's the experience there, when we look at some of the mortality data. Or I guess the mortality is kind of hard because the numbers are so low, and so what other outcomes you might have, you know, either with substance use, mental health, or some of the other chronic disease, you know, tracking how those things are managed. Are there any states with that one-year postpartum?

MS. HEBERLEIN: So not officially. Some states are looking at it. My understanding is South Carolina did not get fully approved in their waiver to do that. There are a couple of other states. ACOG is tracking that pretty closely, so there's a map that sort of says who is looking at it.

Sort of unofficially, states that have expanded Medicaid to the new adult group, presumably women who are under 133, so a lot of states cover pregnant women up to a

higher income threshold, right, and so women who are under 133 would presumably move to the new adult group after their 60-day postpartum period ends. So those women would have -- would continue to have Medicaid coverage, although it wouldn't be as a pregnant woman.

So I have not looked at the outcomes, you know, in that way, but that's certainly, you know, maybe something we could take a look at.

COMMISSIONER CERISE: Okay. And then finally the last one is around access, and you talked about access in the various trimesters. Do we know about access to specialty services during that time period as well?

MS. HEBERLEIN: Yeah. So that's something I'm going to go back and look and see what else we can get out of the PREMs data and if there are additional services we can pull as well as sort of trying to look at the particular timing of when coverage begins, when they access services.

COMMISSIONER CERISE: Because that can be an issue too.

MS. HEBERLEIN: Yeah.

CHAIR BELLA: Martha, then Chuck.

COMMISSIONER CARTER: Referencing, perhaps, Peter's question about access to services prior to pregnancy, I don't know if we can do this, but is there any way to discern the women who were newly enrolled in Medicaid when they became pregnant? A very important issue in the health of the mother is whether she entered pregnancy as healthy as possible. Did she have access to primary care so that her diabetes was controlled or oral health was in good shape, you know, her behavioral health issues were stabilized?

And so can we get a sense of which women came into pregnancy uninsured and, you know, we take a guess at maybe they didn't have, you know, much in the way of primary care before they became pregnant? I'm maybe kind of fishing, but you know what I'm trying to get at is the importance of pre-pregnant primary care.

MS. HEBERLEIN: Yes, and I think we can try to figure out some of that with more of the -- like looking back at that survey to see if there's -- you know, I mean, it's not going to give you the exact answer, because it's only like a certain look-back period, but we can poke around a bit more on that area.

CHAIR BELLA: Chuck has withdrawn his question. Any other comments from Commissioners? Peter.

COMMISSIONER SZILAGYI: Just a very quick contextual comment. The 700 maternal deaths is an amazing tragedy, but we shouldn't let that overshadow the enormous public health impact of low birth weight, and in both the short-term and long-term impact on morbidity and on costs, and impact on the Medicaid program itself.

CHAIR BELLA: Toby.

COMMISSIONER DOUGLAS: And is there also a way to look at where the providers, specifically FQHCs, to just kind of see their role in outcomes, understanding kind of which provider types?

MS. HEBERLEIN: I don't think you are going to get what you want from these data, because it is -- they don't have -- other than -- sorry, I'm trying to just find it on here, because other than the hospital and freestanding birth center, I don't think they get any -- and then they do have clinic or doctor's office, which would presumably include, but that's just place of birth, right. And so that was a super small number.

So I don't know where else we would get sort of

how, you know, earlier primary care in other settings and in FQHCs and how that all sort of fits together, but I can do some more thinking on that.

CHAIR BELLA: So you call this is of great interest to us. You are leaving with like 50 more requests for data. Maybe half of those you can find something on. But we appreciate your willingness to look, and look forward to coming back to this in January and February. Thank you.

CHAIR BELLA: All right. We are ready for our last session, which is to review the draft chapter on disproportionate allotments. So Ryan has the pleasure of the final session.

Welcome. Whenever you're ready. Thank you.

REVIEW OF DRAFT CHAPTER ON STATUTORILY REQUIRED ANALYSES OF DISPROPORTIONATE SHARE HOSPITAL PAYMENT

* MR. GREENFIELD: Good morning, everyone. So my presentation today reviews the draft chapter on disproportionate share hospital allotments for the March report to Congress, and that will fulfill the Commission's annual reporting requirement.

As you know, states are required to make DSH payments to hospitals with a high share of low-income and Medicaid patients. States have flexibility to determine which hospitals receive DSH payments from within capped federal allotments, and can make payments up to a hospital-specific limit, determined by hospitals' uncompensated care costs.

Each year, MACPAC is required to report on the number of uninsured individuals, on the amounts and sources of hospital uncompensated care, and on the hospitals with high levels of uncompensated care that also provide essential community services. Key findings from our analyses represented to the Commission at the October meeting and feedback from you all on these findings was included in the chapter, which is in your materials.

So I am not going to walk through all of the key findings today but will instead provide an overview of the chapter. So in response to the Commissioners' feedback, we included a recap of prior recommendations related to DSH at the beginning of the chapter, following the key findings.

So just to recap those recommendations, first in 2016, in MACPAC's first required DSH report, MACPAC made

the recommendation for the Secretary, the HHS Secretary, to collect additional hospital-specific data on Medicaid payments to hospitals in order to inform future analyses of DSH policy and provide broader oversight of Medicaid payments to hospitals. This recommendation was addressed in the Medicaid Fiscal Accountability Rule recently proposed by CMS.

In March 2019, MACPAC issued a package of three recommendations affecting how pending DSH allotment reductions should be structured. While there has been no action to date on these recommendation there has been legislation in both houses of Congress to delay the DSH allotment reductions.

Finally, in June 2019, MACPAC recommended clarifying the statutory definition of Medicaid shortfall. While litigation is continuing and there has been no legislative action to date, it is important to note the latest version of the drug pricing legislation released by the Senate Finance Committee would enact MACPAC's recommendation.

Next, just to highlight some of the analyses throughout the chapter compare the fiscal year 2020 DSH

allotments to levels of state uncompensated care and other factors that Congress has asked MACPAC to consider. These analyses assume that the $4 billion in DSH allotment reductions scheduled for fiscal year 2020 will take effect as required under current law. However, these sections of the chapter are subject to change if Congress delays the DSH allotment reductions.

Finally, to highlight, the chapter also includes our review of the final evaluation of California's Global Payment Program, which is an 1115 waiver that allows the state to distribute DSH funding through a global payment to public hospitals. This section expands on our discussion at the October meeting by including additional content and context about California's Medicaid payment reforms that preceded the approval of the GPP.

So as Moira and Rob presented to you yesterday, CMS proposed the Medicaid Fiscal Accountability Rule on November 18th, which would require states to collect and report many of the data elements that MACPAC recommended in its first DSH report, including the amounts of supplemental payments to hospitals and the sources of non-federal financing for those payments.

While we don't get into all the changes in the proposed rule in the draft chapter, we note the extent to which the rule addresses the Commission's recommendation. The rule would also strengthen the requirement for states to recover federal funding associated with DSH overpayments identified in the annual DSH audits. It requires auditors to quantify the effects of any deficiencies, identified, in the audit, on the hospital-specific limits, and clarifies that DSH overpayments to hospitals must be recovered and redistributed within two years of discovery. Finally, it eliminates the requirements that DSH allotments be published in the Federal Register, and instead commits CMS to posting these allotments on Medicaid.gov and in the Medicaid Budget and Expenditures System as soon as they are available.

Finally, I would like to highlight that the draft chapter includes updates of data and tables that we have included in prior year reports. These include descriptions of the characteristics of DSH hospitals, the financial margins of DSH and non-DSH hospitals, and state-level data related to factors like uninsured and low-income populations, as well as uncompensated care.

So in terms of next steps, we welcome Commission feedback on the draft chapter. The chapter will also be reviewed externally by subject matter experts. We will incorporate this feedback as appropriate prior to publication. And finally, as I mentioned, you know, many sections of the chapter remain subject to change pending resolution of the amount of DSH allotments that will be available for 2020, and we will make updates accordingly.

So that concludes my presentation and I am happy to answer any questions, and am looking forward to your feedback.

CHAIR BELLA: Thank you, Ryan. Comments or questions from Commissioners?

EXECUTIVE DIRECTOR SCHWARTZ: It was perfect.

CHAIR BELLA: See, the briefing in October was so thorough, and the ambiguity of what is hanging out there I think probably lends it to a pretty quick discussion from us today. But anything you want to raise? Yes. Fred, thank you.

COMMISSIONER CERISE: Both comments. First, thanks. It's great work, as usual. It is just full of -- the information is very good.

One observation. I couldn't tease out the exacts. There are some stats in there that looks like between 20 and 50 percent of this charity bad debt category, which is growing, is among insured individuals, which I think just says something about where we are moving with the insured and how much insurance is still leaving a gap there. Just an observation.

And the other one is in the Medicaid rules the idea that you would sort of track the source of the state share now and report on that is very helpful, and it will give us a clearer picture of how states are targeting or not targeting those DSH payments to deemed hospitals. And so I think that's a helpful piece.

CHAIR BELLA: Why don't I go ahead and invite -- thank you, Fred -- public comments, and then we can come back to the Commissioners.

PUBLIC COMMENT

* MS. SCHWARTZ: Good morning. I'm Rachel Schwartz with America's Essential Hospitals. I'm sure some of you were expecting Zina, but she couldn't make it today.

America's Essential Hospitals would like to thank the Commission for the opportunity to provide comments

today. We also thank the Commission and its staff for its thoughtful work on the DSH program.

America's Essential Hospitals continues to urge the Commission to clearly communicate the impact that the impending DSH reductions will have on hospitals and communities across the country. This is especially key if there is further legislative action on the DSH allotment reductions.

The magnitude of these cuts cannot be overstated, especially with the steep cliff of the reduction schedule where two-thirds of funding will be wiped out within two years. This crucial funding stream will effectively be gutted, a funding stream that currently does not cover all uncompensated care costs shouldered by essential hospitals. This will have a great impact on patients and the essential hospitals that care for those patients. This must be made clear to Congress and policymakers.

Further, the association urges the Commission to provide recommendations around better targeting of DSH funds to hospitals with high levels of uncompensated care, but also provide access to essential community services. Targeting to hospitals within a state is just as important

as allocating the ACA-mandated DSH reductions among states.

Targeting will be especially important if the reductions to Medicaid DSH are fully implemented as scheduled. They cannot be separated. Thoughtful targeting is key to ensure the mission-driven hospitals that currently serve a vital role in their respective communities are supported.

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

CHAIR BELLA: Thank you. Other comments from the public?

[No response.]

CHAIR BELLA: Toby.

COMMISSIONER DOUGLAS: Just a comment on the value-based payments and the global payment program, that I am channeling Sheldon and it is important to him too, that we continue to evaluate and learn from approaches that move towards value-based payments and DSH. And so as we do more reports just continue to assess and get updates on that.

CHAIR BELLA: Any other comments from

Commissioners?

So I would ask that if the Commissioners, upon review, have any additional sort of comments, you need to let Ryan and Anne know quickly. Otherwise, I think you are in great shape. Thank you for this, and we also will look forward to seeing what happens in Congress. Thank you very much.

MR. GREENFIELD: Thanks.

CHAIR BELLA: Any other comments or questions from any Commissioners before we break?

[No response.]

All right. Then we are adjourned. I want to take a moment to thank Anne and the staff for another very productive meeting, and wish you all happy holidays. Thank you.

* [Whereupon, at 11:07 a.m., the meeting was adjourned.]