

**TASK FORCE ON
HEALTH CARE COVERAGE FOR ALL OF MAINE**

Draft Meeting Agenda

September 12, 2018

9:30 am to 1:00 pm

Room 220, Cross State Office Building

- ❖ Welcome and Introduction of Chairs and Members

- ❖ Update on Status of Sec. 1332 Waiver and Medicaid Expansion

- ❖ Structure of the Health Insurance Market Study Group Update

- ❖ Controlling Costs Study Group Update

- ❖ Public Options Study Group Update

- ❖ Discussion of Next Steps/Plans for Study Groups

Public Comment (*at discretion of the chairs, time permitting*)

Task Force on Health Care Coverage for All of Maine
Public Options Study Group
September 12th Update

Following the May task force meeting, the Public Options Study Group met four times by conference call. The Study Group members are Sen. Gratwick, Rep. Foley, Dan Kleban and Kevin Lewis. Rep. Sanborn has also listened in on some calls. To facilitate public access, staff moderated the calls from the IFS Committee Room so members of the public could attend the meeting or listen through the audio links on the Legislature's website

The primary purpose of the calls was to discuss current and past health care reform efforts in several states and to discern what lessons could be learned as the study group considers potential recommendations for health care policy changes.

The following conference calls were held by the Study Group:

- ❖ **Wednesday, July 25th from 12:00 pm to 2:00 pm** with Trish Riley, former Director of the Governor's Office of Health Policy and Finance and current task force member. Ms. Riley provided her perspective on the former Dirigo Health Program here in Maine.
- ❖ **Wednesday, August 15th from 9:00 am to 11:00 am** with Dr. Deb Richter. Dr. Richter is a physician and board member of Vermont Health Care for All. She discussed universal health care efforts in Vermont.
- ❖ **Wednesday, August 22nd from 12:00 pm to 2:00 pm** with Lyn Gullette, Co-Operate Colorado, and Ivan Miller, Colorado Foundation for Universal Health Care. They discussed universal health care efforts in Colorado.
- ❖ **Wednesday, September 5th from 9:30 am to 11:30 am** with John Colmers, Vice President, Health Care Transformation and Strategic Planning, Johns Hopkins Medicine. Mr. Colmers discussed health policy efforts in Maryland, including global budgeting and rate setting.

Brief summaries of each conference call are attached.

**Task Force on Health Care Coverage for All of Maine
Public Options Study Group
Meeting Notes—July 25th Conference Call**

The Study Group had a conference call on Wednesday, July 25th (Dan Kleban was unable to participate). The primary purpose of the call was to discuss Maine's earlier health care reform effort, the Dirigo Health Act, and to discern what lessons could be learned as the group considers potential recommendations for health care policy changes. Trish Riley, who was the Director of the Office of Health Policy and Finance when the Dirigo Health Act was developed, participated in the call and provided her insights and perspective on Dirigo.

Overview/context of Dirigo. Trish Riley noted that context is important when reflecting on the Dirigo Health Program—the individual health insurance market was in a death spirals premiums were very expensive and \$15,000 deductible policies were commonplace. Dirigo Health attempted to reform the entire system by addressing cost, quality and access through a public/private approach. Ms. Riley believes the type of approach is solid. She noted that Dirigo was in some ways ahead of its time and that the federal Affordable Care Act adopted similar provisions, except that Dirigo provided subsidies to employees of small employers as well as individuals. Ms. Riley explained that Dirigo was able to provide health coverage to approximately 47,000 individuals and 1000 small businesses during its years of operation and helped to lower Maine's rate of uninsured between 2003 and 2011. During its operation, however, Dirigo's funding and the use of savings offset payment as a funding mechanism was very complicated, controversial and politically divisive. Legal challenges and the people's veto of the beverage tax reduced Dirigo's ability to have all of the necessary funding.

Lessons learned. Ms. Riley pointed to 3 key factors for any health care reform efforts moving forward: 1) affordability of health care—costs must be lower; 2) funding/how to pay for reform; and 3) sustained bipartisan support.

1. Affordability of health care—costs must be lower
 - Study group agreed with this assessment
 - Suggestions for addressing costs include: global budget; rate-setting; merging of health insurance markets; explore shared risk models between state entities, insurers and providers; accountable care organizations; changes to Certificate of Need process

2. Funding/how to pay for reform
 - Study group briefly discussed the need for sustained funding that has bipartisan support
 - Also noted importance of being able to leverage and maximize federal funding

3. Sustained bipartisan support
 - Study group agreed that sustained bipartisan support is most important to the success of any reform

- Ms. Riley suggested that focus should be on long-term solution and a slow approach to bring lawmakers and the public to the solution over time
- Asked the study group to consider incremental reform as a precursor to larger reform to set foundation for long-term success and bipartisan support
- Study group discussed policy recommendations to address pharmaceutical costs as first step
- Important to establish trust and consensus among different stakeholders and interests
- If incremental approach is taken, then first step must be successful—it must be chosen carefully
- Study group also discussed the establishment of a joint select committee or joint standing committee focused on health care reform so that legislators could develop policy recommendations and expertise and maintain oversight over any enacted reforms
- Study group also noted that the “politics” of these issues will be tough and difficult to address in bipartisan manner given different ideologies and priorities

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**Task Force on Health Care Coverage for All of Maine
Public Options Study Group
Meeting Notes—August 15th Conference Call**

The Study Group had a conference call on Wednesday, August 15th (Rep. Foley was unable to participate). The primary purpose of the call was to discuss Vermont's current and past health care reform efforts and to discern what lessons could be learned as the group considers potential recommendations for health care policy changes. Dr. Deb Richter, who is a primary care physician and founding board member of Vermont Health Care for All, participated in the call and provided her insights and perspective on Vermont's health care reform initiatives. Dr. Richter responded to several questions from the study group members posed by Sen Gratwick.

1. *Green Mountain Care (GMC) was initially conceived of as a bold step toward a single payer system (2011) and has now evolved in to value based, multiplayer, ACO based model. With hindsight was the bold initiative ever possible? Knowing what you know now would you have proceeded down the same path in 2010-2012 or would you have chosen a different path?*

In her view, Dr. Richter believes a single payer or "single spigot" through which health care coverage for all will be funded is inevitable. She thinks reform is further away at the national level than the state level; she suggested that states can be bold in their approach and are more likely to enact reforms. Given the current problems in many states with rising premiums and shrinking coverage, she believes Congress may be more amenable to providing flexibility and waivers to states than to enact federal legislation.

After what happened in Vermont, Dr. Richter suggested that whole system reform is a long-shot to do all at once. She explained that she had recommended in the early stages of Vermont's efforts that advocates and policy makers pursue reform to publicly fund one sector of care first, hospital care. She believed that that would be easier to accomplish initially and, if successful, would facilitate additional incremental reforms to the entire system. Dr. Richter noted the success of an initiative in Rochester, New York to fund hospital care in the early 1990's that reduced hospital costs and insurance premiums and directed the study group to review a Government Accountability Office report on the initiative. Staff agreed to provide members with a copy of the GAO report. While participation in the Rochester initiative was not mandatory, Dr. Richter recommended that any similar policy proposals must require mandatory hospital participation.

Dr. Richter briefly reviewed the history of Vermont's reform efforts toward universal health care and attributed its failure to the lack of political will to impose the taxes that would be required to fund the public/private model ultimately recommended by Governor Shumlin and the Green Mountain Care Board.

Dr. Richter explained that current reform efforts in Vermont are focused on universal primary care. Advocates believe that the proposal has broad appeal to all stakeholder interests and provides the "biggest bang for the buck". While the proposed legislation failed in committee at the end of the most recent legislative session, she expects that a new bill will be introduced in the next session. Initial studies of the proposal, which would include funding for primary care and outpatient substance abuse and mental health services with no copayments and deductibles, estimate that primary care spending

accounts for about 6% of Vermont's total health care spending and that approximately \$200 million in additional funding would be needed. Advocates have considered adding coverage for generic drugs (the "Walmart list"), but prescription drug coverage was not included in the legislative proposal. Staff will provide members with a copy of Vermont's Universal Primary Care bill.

2. *What contributed to the demise of Green Mountain Care?*

Dr. Richter noted several factors that led to the failure of Green Mountain Care, including:

- the State's inability to pursue a waiver/establish a pilot under the ACA through a Sec. 1332 waiver until 2017---plan lost momentum from the delay;
- the loss of political support for Governor Shumlin; and
- taxes---estimated \$2.4 to 2.6 billion in new taxes was too much.

Dr. Richter also pointed out that several studies conducted by Vermont did demonstrate that overall health care spending would be lower if Green Mountain Care were fully implemented. It did not fail because the proposal was not feasible, but due to politics and funding.

Dr. Richter reiterated her belief that a universal primary care program could be successful at the state level. Under the proposal, she described how primary care providers would be paid under a capitated, risk-adjusted arrangement. Mental health and substance abuse services would be paid for on a fee-for-service basis. Provider would still be required to submit claims as under the current system. As she mentioned previously, an additional \$200 million in additional revenue would be needed. Dr. Richter suggested that a broad range of revenue sources would be preferred, but that the funding for UPC in Vermont could be provided through a 1.5% payroll tax.

If universal primary care was provided and health insurance premiums were reduced, study group members expressed some concerns about the potential for adverse selection on the individual market and the negative impact on the amount of the advanced premium tax credit/subsidy for marketplace enrollees. Dr. Richter replied that some of those concerns were raised during Vermont's consideration of the recent proposal; it was not expected that premiums would change that much as it was estimated that primary care costs accounted for 6-8% of current health insurance premiums in Vermont. Dr. Richter did acknowledge that health plans on the marketplace/exchange may need to be recalibrated if such a proposal were implemented and that compatibility with health savings account was another concern raised in Vermont.

3. *Your thoughts on cost containment?*

Dr. Richter suggested that the following policy efforts should be explored to contain costs:

- Require global revenue budgets for hospitals that separate operating expenditures from capital expenditures (although she noted the substantial political clout hospitals have in rural states like Maine and Vermont);
- Require a single prescription drug formulary be used by all payers, public and private, perhaps based on the current Medicaid formulary.

Study group members asked about the potential negative financial impact on providers with a global budget. Dr. Richter responded that Vermont is experiencing a provider exodus now due to problems with current system, but that any global budget must be designed so that providers are not paid substantially less than current salaries. She also noted her belief that a global budget system may increase the bargaining clout of providers.

4. *Should GMC have made the decision about financing upfront?*

Yes, Dr. Richter believes the decision about how to fund Green Mountain Care should have been done at the outset. It was a mistake to wait for political reasons. The public should have been educated from the beginning about the costs of the proposal and how it would affect them; advocacy groups did eventually provide “calculators” and other information to educate the public, but it was too late to be effective.

5. *Was the role of the GMC board as a regulatory entity with a quasi-judicial under the control of the Governor role a good idea?*

Dr. Richter stressed how important the written legislation is when establishing an oversight entity, particularly noting that specific representation of stakeholder interests should be included in the law. For example, the current Green Mountain Care Board does not have a provider representative. Appointments are made by the Governor and, as such, are subject to politics. Dr. Richter also stressed that the Green Mountain Care Board is a public entity and conducts its meetings in a transparent public manner; in her view, this makes the board accountable. The GMC board did work very well in its early stages and currently has several functions, including review of health insurance rates and oversight of hospital budgets and certificate of need.

6. *Did GMC address long-term/chronic illnesses or address social determinants of health (housing, childcare, transportation, etc.)?*

Dr. Richter explained that Vermont has put forward several initiatives directed at social determinants of health:

- The ACO (accountable care organization) model is directed at overall health improvement and better management of long-term and chronic illnesses; and
- The “Blueprint for Health” has developed public health programs, including embedding health educators in primary care practices and providing funding for therapists/nurses for substance use disorder treatment.

7. *Thoughts on financing/need for waivers from the federal government?*

Dr. Richter acknowledged that any health reform effort will require federal waivers in order to maximize federal resources. In terms of financing, she described that Vermont has focused primarily on the use of payroll taxes. It was estimated that a 1% payroll tax would equal \$130 million in revenue. Other types of taxes would not provide that much revenue. Dr. Richter suggested that public input on financing is important and that many sources of revenue should be explored.

Finally, Dr. Richter mentioned the importance of language and message when pursuing health care reform. She advised the study group to stay away from the term “single-payer” because the focus should be on the health care benefits being provided not on how those benefits are funded or delivered. She recommended describing proposals as Medicare for all at the state level and stressing that health care should be considered a “public good” like police or fire services.

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**Task Force on Health Care Coverage for All of Maine
Public Options Study Group
Meeting Notes—August 22nd Conference Call**

The Study Group had a conference call on Wednesday, August 22nd with Lyn Gullette, Executive Director of Co-Operate Colorado, and Ivan Miller, Executive Director of the Colorado Foundation for Universal Health Care. The primary purpose of the call was to discuss Colorado's current and past health care reform efforts and to discern what lessons could be learned as the group considers potential recommendations for health care policy changes.

Ms. Gullette and Mr. Miller responded to several questions from the study group members posed by Sen Gratwick.

1. What have you learned after defeat of universal health care effort? What recommendations for moving forward?

Ms. Gullette and Mr. Miller provided the following comments about the defeat of Amendment 69 in Colorado. The universal health care effort sought to amend Colorado's State Constitution.

- Colorado Care was designed to provide coverage for all Coloradans; benefit plans would provide wrap around services for those covered by Medicare, Veterans Administrations and Indian Health Service
- Plan did not mandate employer participation but it was expected that self-funded employers would drop coverage given new taxes for funding
- Estimated that administrative costs could be lowered 10-12%
- Political defeat was primarily due to lack of funding for campaign—political establishment in Colorado (including Governor) was part of coalition opposed to Amendment 69; spent roughly \$500,000 compared to \$5 million for opposition
- Amendment 69 vote: 80% opposed; 20% in favor
- Opposition included health care foundations, progressive organizations and others; advocates expected those to be "friends" to campaign and should have spent more time garnering early support from those groups
- Focus groups and discussion following election pointed out that many voters did not support universal health care because they did not completely understand plan---points out that lots of education was needed and lack of \$ hindered efforts to educate voters
- Amendment 69 designed Colorado Care to be run as a co-operative health plan separate from government so that health plan could operate independently and insulated from politics
- Future efforts need business support, especially small businesses, in order to succeed
- Reform effort did include information and analysis of estimated costs of plan for individuals and businesses---this was lesson learned from failure in Vermont

2. Maine is a state dominated by small businesses, many of which do not offer coverage currently. How did Colorado's efforts address fact that overall costs would increase for those businesses?
 - Intent of Colorado Care was to include workers' compensation coverage within the plan so many small employers would have experienced savings
 - Case by case determination though and there would be some small employers with potential cost increases

3. How did plan account for long-term costs and viability? Health care costs are increasing at rapid rate.
 - Plan designers believed that Colorado Care could slow costs to average rate of medical inflation
 - Anticipated that after 9 years there would be a needed tax increase
 - Rising prescription drug prices were concern

4. How was Colorado Care developed before initiative was put on ballot?
 - Was initially introduced as proposed legislation, but failed in Legislature
 - Original legislative sponsor mean that legislative staff helped to draft proposal
 - Small legislative committee reviewed draft legislation and made changes
 - Believe proposed amendment to Constitution should have been more explicit about 2 issues that caused confusion during campaign---should have been more explicit about coverage for abortion services and wraparound coverage to Medicare for seniors

5. Was there any analysis of potential job loss or job creation if Colorado Care were implemented?
 - There was no expected decrease in jobs for medical professionals
 - Some job churn was anticipated ---30K to 50K jobs
 - Potential savings for economy/businesses believed to be stimulus for creation of 50,000 additional jobs after first few years

6. Can you talk about the grass-roots advocacy and process for getting to ballot initiative?
 - Critical need for grass-roots support and volunteers
 - After several legislative failures (3 in 7 years), advocated worked to get initiative on ballot---500 volunteers gathered necessary signatures (*never received majority support of Legislature*)
 - However, once initiative on ballot, effort needed experienced field directors to help organize and fund campaign to get Amendment 69 passed
 - Will send notes summarizing insights from volunteers after election defeat
 - Need more endorsements and assistance from partner organizations and aggressive PR/public education campaign to counter opposition
 - Even with 1 year after initiative qualified for ballot to election, believe there was not enough time

7. How were potential legal issues related to ERISA addressed in legislation?
 - Amendment 69 was drafted to require taxes for state health care program generally
 - Taxes required and received from employers without any requirement that they opt in to coverage
 - Believed that approach would survive legal challenge—modeled on Vermont approach—but understood that there would likely be lawsuit

8. Where is Colorado now? Are there continued reform efforts?
 - Considering introduction of bill in next legislative session to require economic analysis of current system and 2 new design options (single payer plan and public/private plan)
 - Anticipate another bill for universal health care and potential ballot initiative in 2020

9. What about cost containment? Was it addressed in Colorado Care?
 - Not explicitly addressed
 - Expectation that once coverage provided for all residents and that goal becomes aligned with best interest of public, then it would be easier to address how to contain costs and stress preventive services
 - Hard to be too specific because mechanism used was constitutional amendment, not statutory change
 - Believe Vermont may have made mistake trying to address universal coverage and payment reform at same time

10. Any comments on global budgets? Spending?
 - Colorado Care initially based on tax system
 - No tax increases expected for several years
 - Designed to hold \$5 billion in reserve to account for unanticipated spending

**Task Force on Health Care Coverage for All of Maine
Public Options Study Group
Meeting Notes—September 5th Conference Call**

The Study Group had a conference call on Wednesday, September 5th with John Colmers, Vice President, Health Care Transformation and Strategic Planning, Johns Hopkins Medicine. (Dan Kleban was unable to participate.) The primary purpose of the call was to discuss health policy efforts in Maryland, including the global budgeting and rate setting waiver, and to discern what lessons could be learned as the group considers potential recommendations for health care policy changes. Rep. Foley also provided comments on the health care system in Iceland following his recent trip there.

Mr. Colmers gave an overview of Maryland's All Payer Waiver. See slide presentation, <\\Legnas1\opla\STUDIES\STUDIES 2017\Health Care Coverage for All of Maine\Public Options Study Group\hctSPEnhanced Model Overview - Maine Task Force -090518 - PDF - FINAL.pdf>

Mr. Colmers made the following points:

- All payers are included—Maryland has had Medicare waiver since 7/1/77 and Medicare pays hospital rates set in MD by Maryland Health Services Cost Review Commission
- No “cost shifting” as all payers, public and commercial, pay same rates
- MD updated approach in 2014—new waiver with federal government that looks at total cost of care, not just hospital rates
- MD Commission has broad authority to implement policies that all hospitals and payers must adhere to
- Has had wide support from hospitals and payers—may be unique to MD
- Not a lot of detail built into statute by design; the Commission is charged with:
 - Allow for reasonable costs
 - Recognize relationship between reasonable costs and rates
 - May not set rates that are unduly discriminatory
 - Efficient and effective rate setting must maintain solvency of hospitals
- Statute has been largely left alone—no substantive amendments in many years (staff will provide copy of Maryland statute)
- Updated waiver in January 2014 moved toward global budget model (aggregate hospital spending); will transition to Total Cost of Care Model in January 2019
- Conditions of 2014 waiver included: 1) limiting growth to 3.58% per year; 2) 80% of hospital revenue must be in global model by 2018; and 3) Medicare savings of 0.5% per year or \$330 million over 5 years
- Global budget model results for first 3 years showed that average growth was 1.53%; Medicare savings of \$586 million and 100% of hospitals were participating in model; other result metrics were also impressive

- New "Total Cost of Care" model designed to coordinate care in both hospital and non-hospital settings and constrain growth of costs
- Will build on global budget model and also seeks to improve population health
- Negotiations for new waiver/model took more than 2 years; first submitted 2016 and finally approved in 2018
- Limits growth in total cost of care with estimated savings to Medicare of more than \$1 billion
- Anticipate that providers will receive additional reimbursement for participation in care redesign models (model will bring physicians, nursing homes and other providers into aligned programs to deliver care); MD has flexibility for design and implementation of models
- Ambitious effort, but believes MD can achieve success based on success of prior waivers

Mr. Colmers also responded to several questions.

1. How does the Commission address emerging technologies in setting rates?
 - Commission has paid increasing attention to emerging technologies (biologics, implants, etc.) as many are delivered in an inpatient setting
 - Considering adding separate cost, although currently built into rates
 - Noted that costs are not evenly distributed among hospitals; academic hospitals especially are affected
 - One example of biologic developed by Johns Hopkins costs \$750,000 for treatment in first year and \$350,000 annually for maintenance treatment
2. How were models developed? Any stakeholder input?
 - Ongoing conversations with stakeholders as most recent waiver negotiated by Commission with federal government
 - Tried to be as inclusive and transparent as possible
3. How does Legislature relate to work of Commission?
 - Legislature has oversight over Commission's statute and budget
 - Committee oversight in both House and Senate
 - No recent legislative changes to statute
4. Can you comment on Commission's budget?
 - Operating budget is approximately \$6-7 million annually
 - Complicated because Commission also oversees and receives and distributes payments for MD's Uncompensated Care Pool
 - Uncompensated Care Pool redistributes overpayments and underpayments among hospitals; flat amount included in rates set by Commission but overpayment/underpayment determined later

5. Can you comment on administrative costs?
 - Agreed that it can be problem and needs to be addressed
 - MD has experienced some growth in physician practices, but # of large hospital systems (3) has remained constant over many years

6. How do rural hospitals feel about rate-setting/global budget system?
 - Rural hospitals support system
 - Reasonable rates keep hospitals solvent
 - Noted that PA is pursuing similar waiver focused on rural hospitals

7. Are cost savings 2014-17 related primarily to decreased admissions?
 - Data shows that length of stay not affected

8. How do you incentivize medical providers to participate? How to improve the coordination between hospitals, providers and those dealing with the 'social determinants of health'?
 - Reiterated that enhanced reimbursement model will be used for providers who participate in new total cost of care model
 - Commission is in early stages of thinking on how to address social determinants, but it will be part of future

9. What is the reason for the discordance between Medicare patient's and private insurance patient's usage of the ER and Observation Units?
 - Acknowledge that one analysis of MD shows this, but unsure why
 - Commission is trying to determine cause

10. What are the reasons for low patient satisfaction in Maryland?
 - Commission is putting more \$\$ at risk for hospitals with low patient satisfaction rates
 - Has been problem for many years
 - MD has demonstrated success in reducing rates of readmission and believe that will impact patient satisfaction measures over time

11. How have you dealt with the need for common IT among all hospitals and providers?
 - MD has robust Health Information Exchange (HIE)
 - Funding for this infrastructure has been built into rates and provided to hospitals
 - Standards/systems not mandatory so trying to increase uniformity and compatibility of systems currently being used

12. What are the politics of all-payer? Who is for, who against?
 - Developed strong coalition of support over time
 - Some worry expressed about success of new model, but status quo is not sustainable; new model is needed long-term
 - Was challenge to get Medicare to think differently
 - States have flexibility to explore different options

- Can't say whether MD model can be replicated elsewhere—MD has unique culture, location and system

On a recent visit to Iceland, Rep. Foley met with their Minister of Health to learn about Iceland's health care system. Rep. Foley noted that he did not believe a state like Maine could adopt the Iceland model because of several factors unique to Iceland. He provided the following comments:

- Iceland's system is centralized, government-funded and government-operated
- Iceland has 1 major hospital in capital and 80% of Iceland's 348,000 residents live within 20 miles of the hospital; rural areas have access to medical clinics and medical helicopters used to transport more acute cases to capital for treatment
- Health care costs account for 25% of total national budget; Iceland has income tax rate of 46.3% and 17.5% of that tax goes to health care
- Delivery of prescription drugs is done privately
- Comprehensive coverage although dental and vision care provided only for children
- Deductibles and copayments determined individually based on income and are adjusted annually
- 86% of Iceland residents satisfied
- Uncompensated health care costs for services delivered to tourists continue to increase
- Many physicians trained in other countries and return to Iceland; also recruit physicians from other countries—more willing to work in capital than in rural areas

Task Force on Health Care Coverage for All of Maine
Structure of the Health Insurance Market Study Group
September 12th Update

The Structure of the Health Insurance Market Study Group has met five times to date: March 26, April 23, May 21, July 24 and August 28. The following members of the Study Group have regularly attended meetings: Rep. Anne Perry, Kristine Ossenfort, Joel Allumbaugh and Frank McGinty. Sen. Gratwick also attended the April 23, May 21, July 24 and August 28 meetings.

The Study Group focused on the consideration of policy recommendations related to the individual and small group health insurance market. The members hoped to develop recommendations that would target certain populations experiencing problems related to health insurance coverage in the existing market, including:

- Individuals who have incomes below 100% of the federal poverty level who do not qualify for the APTC (advanced premium tax credit);
- Individuals who are “lightly subsidized” and particularly sensitive to health insurance premium increases;
- Individuals who have incomes above 400% of the federal poverty level who do not qualify for the APTC (advanced premium tax credit); and
- Those enrolled in small group health insurance.

Study Group members noted that current federal law and uncertainty related to the action/inaction of the federal government are important factors in whether possible policy solutions can succeed at the state level to improve the affordability and stability of the health insurance market in Maine. Another significant factor not directly addressed by the study group is the underlying cost of health care; the efforts of the Controlling Costs Study Group and policy recommendations to control health care costs are very important.

The Study Group considered a number of possible policy options and identified the advantages and disadvantages of each policy option and the potential barriers to implementation. The Study Group also discussed the importance of having data to inform its policy recommendations and talked with the Maine Health Data Organization about whether its claims database could be more rigorously utilized to determine cost drivers, cost variations, trends and quality. The Maine Health Data Organization provided certain information related to health care claims costs requested by the Study Group. See attached.

Unless noted, the comments below represent the consensus of the Study Group members. The Study Group provides these preliminary comments and potential recommendations for consideration by the task force:

- ❖ *Continue to study and analyze possible statutory changes, including changes related to Maine’s reinsurance mechanism (MGARA), the segregation of the individual risk pool, the definition of small group, and the determination/counting of full-time equivalent employees for insurance purposes*

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While the members initially discussed a recommendation to seek a waiver to restart operations of Maine's reinsurance mechanism (MGARA) back in April, that recommendation is no longer relevant since a waiver request was submitted to and granted by the Federal government. MGARA's operations are expected to resume in January 2019. The members did discuss the potential for making statutory changes that would have an impact on MGARA's operations, including the segregation of the risk pool within MGARA to limit reinsurance to unsubsidized policies or policies sold off the federal marketplace, changing the definition of "small group", merging the individual and small group markets, expanding eligibility for reinsurance to small group policies as well as individual policies and changing the way in which an FTE is determined for insurance purposes. The members decided to recommend that there be continued study, analysis and research done by MGARA and the Bureau of Insurance on these potential policy changes.

- ❖ *Support the continuation of the practice of "silver loading" of ACA marketplace policies to mitigate impact of changes to cost sharing reductions under the ACA*

The study group discussed the impact of the elimination of cost-sharing reductions for enrollees in the federal marketplace that had incomes at or below 250% of the federal poverty level. For many enrollees, the impact of the reduction was mitigated by a practice called "silver loading". Rather than simply raising the cost of all ACA health plans ("bronze," "silver," "gold," and "platinum" plans), insurers added the CSR-related premium rate increases into just silver-level plan premiums. Because the ACA uses the premium for "silver" plans to determine the premium subsidies available to individuals with annual incomes below 400% of FPL, when premiums for silver plans increased, federal subsidies increased along with them. The study group supports the continuation of "silver loading" due to the mitigating effect the practice has had on premium increases for consumers.

- ❖ *Monitor federal activity related to the Sec. 1332 waiver process and consider engaging Congressional delegation to seek changes to streamline the waiver process*

The study group acknowledged that several of the policy options discussed by the study group related to MGARA and the individual and small group market may require a 1332 waiver of certain requirements of the ACA. The requirements of the current waiver process are time consuming. Members noted that the task force should pay attention to activity at the federal level related to the waiver process and consider whether the task force should engage Maine's Congressional delegation to seek changes to streamline the waiver process for states.

- ❖ *Monitor activity in states that have enacted a state-level individual mandate*

The study group discussed whether to recommend a state-level individual mandate to replace the federal mandate following its repeal. One member noted that it would be unfair to recommend such a mandate without providing access to coverage through Medicaid expansion and sufficient financial assistance to purchase health insurance in the face of premium increases. Members wondered whether a mandate would really help without adequate enforcement and affordable options for coverage and

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whether it could be successful at the state level. Members agreed it would be useful to monitor New Jersey and other states that have recently enacted a state mandate. Members also discussed other policy options that could improve the stability of the individual market in the absence of a mandate. Members felt that financial incentives and financial assistance to purchase coverage would be more important than a mandate.

❖ *Support implementation of Medicaid expansion**

A majority of the members support Medicaid expansion and believe the task force should consider a recommendation supporting expansion and efforts to implement expansion.

❖ *Monitor how changes in federal rules for short-term health insurance policies impact Maine's individual market*

The members discussed the recent changes to federal rules related to short-term health insurance policies and reviewed Maine's current law governing short-term policies. Federal regulations governing short-term health insurance policies were changed in early August and become effective for short-term policies sold on or after October 2, 2018. The federal regulations extend the maximum coverage period for short-term policies from 3 months to less than 12 months (or 364 days). The regulation also permits carriers who offer short-term policies to renew those policies for a total of 36 months. The prior federal rule prohibited renewals. Current Maine law mirrors the federal rule by defining a short-term policy as one with a term of less than 12 months. However, Maine law prohibits renewal of short-term policies and limits the maximum coverage under successive short-term policies to 24 months. The federal rule allows states to regulate short-term policies in a more restrictive manner, including prohibiting the sale of short-term policies altogether. It was also suggested that the task force could consider statutory changes to mirror the federal rules. The members agreed that it is important to monitor how the changes in federal rules may impact the sale of short-term policies in Maine health insurance market, the availability and affordability of health insurance coverage and the stability of the market for ACA-compliant individual health plans.

❖ *Monitor implementation of "right to shop" programs by health insurance carriers subject to requirements*

The members discussed whether the "right to shop" program should be expanded to include additional categories of health care services. Because the effective date for health insurers subject to the law to offer health plans with "right to shop" incentives is not until January 2019, the members believe it is premature to recommend changes, but that the program should be monitored to determine if additional changes should be considered.

❖ *Support State funding for navigators*

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Structure of the Health Insurance Market Study Group
September 12th Update

The members discussed the significant reduction in federal grant funding for navigators for the 2019 enrollment period. In terms of federal funding for navigator assistance in Maine, the total amount of funding allocated to Maine for the 2018-2019 program year is \$100,000; this is a significant reduction in total funding as \$551,750 was awarded in 2017. Maine's 2 grantees in 2017 were: 1) The Fishing Partnership Health Plan, which was awarded \$100,000; and 2) Western Community Action Program, which was awarded \$451,750. The application deadline for assistance was August 9, 2018 and the announcement of any funding award for the next plan year is expected on September 12, 2018. The members agreed to suggest that the task force explore recommending that additional state funding be provided for navigators.

- ❖ *Make changes to Maine Health Data Organization statute to strengthen reporting requirements related to health care costs*

During its discussion of the Maine Health Data Organization's capacity to provide health care cost information with Karynlee Harrington, the members talked about amending MHDO's enabling law to improve the cost and quality information available to the public. The members agreed to recommend that statutory changes to Section 8712 of MHDO's governing statutes be considered to strengthen and integrate MHDO's collection and reporting of cost and quality measures.

- ❖ *Monitor health insurance carrier practices related to prior authorizations and review of clinical appeals*

At Sen. Gratwick's suggestion, the members discussed proposed legislation (LD 1032) considered by the IFS Committee that would have made changes to the process for prior authorization and review of clinical appeals. The legislation was not enacted, but the IFS Committee asked the Maine Medical Association to survey its members and to convene informal discussions with health plans and providers about these issues. The study group members agreed to monitor these issues moving forward.

Task Force on Health Care Coverage for All of Maine

Update on Status of MGARA and Medicaid Expansion

Maine Guaranteed Access Reinsurance Association (MGARA): The State of Maine, through the Bureau of Insurance, applied for a Section 1332 State Innovation waiver to the United States Department of Treasury and the Centers for Medicare and Medicaid Services (CMS) within the federal Department of Health and Human Services on May 9, 2018. The request permitted under Section 1332 of the federal Affordable Care Act seeks a waiver of certain provisions of the ACA to permit reinstatement of the Maine Guaranteed Access Reinsurance Association (MGARA) beginning in the 2019 plan year.

The waiver was approved on July 30, 2018. A copy of the approval letter is attached. (pp. A-1 to A-9)

Final rates for the 2019 plan year in the individual and small group markets have been approved by the Bureau of Insurance. See attached chart summarizing average rate increases across all plans by each insurer. (p. A-10)

MGARA's Board of Directors must submit a revised plan of operations to the Bureau of Insurance for approval, consistent with the terms of the waiver. Based on discussions with the Bureau of Insurance, that revised plan of operation is being prepared and is expected to be submitted soon. The first quarterly assessment is expected to be from carriers for 2019 plan year on 12/31/18 and federal funding pursuant to the waiver is expected in April 2019.

Medicaid Expansion: As required by court order, the State of Maine submitted a request for a State Plan Amendment related to Medicaid expansion on September 4, 2018. See attached letter and supporting documents. (pp. B-1 to B-16) Concurrently with the submission of the SPA request, Governor LePage sent a letter on August 31, 2018 to Secretary of the U.S. Department of Health and Human Services Alex Azar and Administrator of the Centers for Medicare and Medicaid Services Seema Verma urging CMS to reject the SPA submitted by the State. See attached. (pp. B-17 to B-19)

It is also my understanding based on newspaper reports that DHHS has or will reject Medicaid applications submitted to DHHS by those individuals otherwise eligible for Medicaid (based on expansion).

A final decision in the lawsuit challenging the Department's position on implementation of Medicaid expansion without additional appropriation of funds is still pending in state court.





Administrator
Washington, DC 20201

JUL 30 2018

Eric Cioppa
Superintendent of Insurance
Maine Bureau of Insurance
#34 State House Station
Augusta, ME 04333

Dear Superintendent Cioppa:

Thank you for your May 9, 2018 submission of Maine's application for a State Innovation Waiver. I am pleased to send this letter from the Centers for Medicare & Medicaid Services (CMS) on behalf of the Department of Health and Human Services (HHS) and the Department of the Treasury (collectively, the Departments).

This letter is to inform you that the Departments, having completed their review of the application, approve Maine's State Innovation Waiver under section 1332 of the Patient Protection and Affordable Care Act (PPACA) as described below and conditioned upon the state's written acceptance within 30 days of the specific terms and conditions (STCs) that are enclosed with this letter. This approval is effective for a waiver period of January 1, 2019, through December 31, 2023.

Maine's application sought waiver of the PPACA requirement for the single risk pool in order to implement the Maine Guaranteed Access Reinsurance Association for 2019 through 2023. The Departments are granting Maine's application to waive the single risk pool requirement in the individual market under section 1312(c)(1) of the PPACA, to the extent it would otherwise require excluding total expected state reinsurance payments when establishing the market-wide index rate for the purposes described in the state's application.

The Departments have determined that implementation of this reinsurance program will lower individual market premiums in the state and the premium tax credits (PTC) to which Maine residents would have been entitled absent the waiver. These PTC savings will be passed through to the state to be used for implementation of the waiver plan.

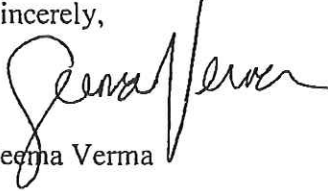
The enclosed STCs further define the state's responsibilities with respect to implementation of the waiver and use of pass-through funding during the waiver period and the nature, character, and extent of anticipated federal oversight of the project. A breach of any of the STCs may lead to termination of Maine's State Innovation Waiver.

Please send your written acceptance and any communications and questions regarding program matters or official correspondence concerning the waiver to Lina Rashid at

Lina.Rashid@cms.hhs.gov, Robert Yates at Robert.Yates@cms.hhs.gov, or stateinnovationwaivers@cms.hhs.gov.

Congratulations and we look forward to working with you and your staff. Please do not hesitate to contact us if you have any questions.

Sincerely,



Seema Verma

cc: David Kautter, Assistant Secretary for Tax Policy, U.S. Department of the Treasury
Marti Hooper, Maine Bureau of Insurance
Holly Doherty, Maine Bureau of Insurance

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES (HHS)
U.S. DEPARTMENT OF THE TREASURY
PATIENT PROTECTION AND AFFORDABLE CARE ACT SECTION 1332 STATE
INNOVATION WAIVER
SPECIFIC TERMS AND CONDITIONS
TITLE: State of Maine — Patient Protection and Affordable Care Act Section 1332 Waiver
Approval
AWARDEE: The State of Maine

I. PREFACE

The following are the specific terms and conditions (STCs) for the State of Maine’s (“the state”) Patient Protection and Affordable Care Act (PPACA) section 1332 State Innovation Waiver (“the waiver”), which has been approved by the U.S. Department of Health and Human Services (HHS) and the U.S. Department of the Treasury (collectively, the Departments). These STCs govern the operation of the waiver by the state. The STCs set forth, in detail, the state’s responsibilities to the Departments during the term of the waiver, which is January 1, 2019, through December 31, 2023. Accordingly, these STCs are effective beginning January 1, 2019, and will terminate on December 31, 2023, unless the waiver is extended as provided by these STCs; however, the Departments reserve the right to amend these STCs when the Departments make the annual determination of the pass-through amount for plan years 2020 through 2023. The state’s application to waive certain provisions of the PPACA – dated May 9, 2018 is specifically incorporated by reference into these STCs, except with regard to any proposal or text in the application that is inconsistent with the Departments’ approval of the waiver or these STCs.

1. PPACA Provisions Waived under Section 1332 State Innovation Waiver. Section 1312(c)(1) of the Patient Protection and Affordable Care Act (P.L. 111–148) is waived to the extent it would otherwise require excluding total expected state reinsurance payments when establishing the market wide index rate for the purposes described in the state’s application.

2. Changes in State Law and the Reinsurance Program. The Maine Guaranteed Access Reinsurance Association (MGARA) is a state-established reinsurance program which aims to reduce premiums for all Mainers in the individual market. MGARA will reimburse qualifying individual health insurers for a percentage of an enrollee’s claims between an attachment point and a cap. MGARA is administered by the State of Maine and the Bureau of Insurance (BOI). The state must inform the Departments of any change in Maine state law or regulations that would impact the waiver, including any changes to the requirements under the MGARA authorizing legislation. The state must report any changes in state law occurring after the date of this approval letter within 30 days of any such changes.

In addition, the state must report any changes to MGARA, such as changes to the approved payment parameters for MGARA reimbursement. Consistent with the waiver application, the State of Maine and the BOI are responsible for any reconciliation of reinsurance payments that Maine wishes to make to account for any duplicative reimbursement through MGARA for the same high cost claims reimbursed through the HHS-operated risk adjustment program.

3. Legislation Authorizing and Appropriating Funds to MGARA. The state must ensure sufficient funds, on an annual or other appropriate basis, for MGARA to operate as described in the state's waiver application.

4. Compliance with Federal Non-Discrimination Statutes. The state must comply with all applicable federal statutes relating to non-discrimination. These include the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, title I and II of the Genetic Information Nondiscrimination Act of 2008 and section 1557 of the PPACA.

5. Compliance with Applicable Federal Laws. Per 31 CFR §33.120(a) and 45 CFR §155.1320(a), the state must comply with all applicable federal laws and regulations, unless a law or regulation has been specifically waived. The Departments' state innovation waiver authority is limited to requirements described in section 1332(a)(2) of the PPACA. Further, section 1332(c) of the PPACA states that while the Secretaries have broad discretion to determine the scope of a waiver, no federal laws or requirements may be waived that are not within the Secretaries' authority. See 77 FR 11700, 11711 (February 27, 2012). Therefore, for example, section 1332 of the PPACA does not grant the Departments authority to waive any provision of the Employee Retirement Income Security Act. The state must, within the applicable timeframes, come into compliance with any changes in federal laws or regulations affecting section 1332 waivers, unless the provision being changed has been expressly waived. The state will comply with requirements of the Cash Management Improvement Act (CMIA).

6. Changes to Applicable Federal Laws. The Departments reserve the right to amend, suspend, or terminate the waiver, STCs, and pass-through funding amount as needed to reflect changes to applicable federal laws or changes of an operational nature without requiring the state to submit a new waiver proposal. The Departments will notify the state at least 30 days in advance of the expected implementation date of the amended STCs to allow the state to discuss the changes necessary to ensure compliance with law, regulation, and policy, to allow the state adequate time to comply with state and federal regulatory requirements, including rate review and consumer noticing requirements, and to provide comment. Changes will be considered in force upon the Departments' issuance of the amended STCs. The state must accept the changes in writing within 30 days of the Departments' notification for the waiver to continue to be in effect.

7. Finding of Non-Compliance. The Departments will review and, when appropriate, investigate documented complaints that the state is failing to materially comply with requirements specified in the waiver application and these STCs. In addition, the Departments will promptly share with the state any complaint that they have received and notify the state of any applicable monitoring and compliance issues.

8. State Request for Suspension, Withdrawal or Termination of a Waiver. The state may only suspend or request withdrawal of all or portions of a waiver plan consistent with the following requirements:

a) Request for suspension, withdrawal, or termination: If the state wishes the Departments to suspend or terminate the waiver, or to withdraw a portion of the waiver, the state must submit a request to the Departments in writing, specifying the reasons for the requested suspension, withdrawal, or termination; the effective date of the requested suspension, withdrawal or termination; and the proposed phase-out plan (with the comment summary described below). The state must submit its request and draft phase-out plan to the Departments no less than six (6) months before the proposed effective date of the waiver's suspension, withdrawal, or termination. Prior to submitting the request and draft phase-out plan to the Departments, the state must publish on its website the draft phase-out plan for a 30-day public comment period and conduct tribal consultation. The state must include with its request and proposed phase-out plan a summary of each public comment received, the state's response to the comment and whether or how the state incorporated measures into a revised phase-out plan to address the comment.

b) The state must obtain the Departments' approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after the Departments' approval of the phase-out plan.

c) Unused pass-through funding will be recovered. The state will comply with all necessary steps to facilitate the recovery within a prompt timeframe.

9. Waiver Extension Request. The state must inform the Departments as to whether the state will apply for continuation of the waiver one year prior to the waiver's end date. The Departments and the state will engage in further discussions to develop guidelines and define next steps for phase-out or continuation of the waiver. If the state does not apply for an extension of the waiver, the Departments will provide guidance on the wind-down of the state's waiver.

10. Reporting: The state will submit quarterly and annual reports as specified in 31 CFR §33.124 and 45 CFR §155.1324. Each such annual report must include:

- The progress of the section 1332 waiver;
- Data sufficient to show compliance with section 1332(b)(1)(A) through (D) of the PPACA;
- A summary of the annual post-award public forum, held in accordance with 31 CFR §33.120(c) and 45 CFR §155.1320(c), including all public comments received at such forum regarding the progress of the section 1332 waiver and action taken in response to such concerns or comments.
- Other information the Departments determine are necessary to determine pass through amounts or to evaluate the waiver.

The state must submit a draft annual report to the Departments within 90 days after the end of the first waiver year and each subsequent year that the waiver is in effect. The state will publish the draft annual report on the state's public website within 30 days of submission to the Departments. Within 60 days of receipt of comments from the Departments on the report, the state must submit to the Departments the final annual report for the waiver year, summary of the

comments, and all comments received. The state must publish the final annual report on the state's public web site within 30 days of approval by the Departments.

The annual reports must include the following:

- 1) Metrics to assist evaluation of the waiver's compliance with the statutory requirements in section 1332(b)(1):
 - a. Actual individual market enrollment in the state.
 - b. Actual average individual market premium rate (i.e., total individual market premiums divided by total member months of all enrollees).
 - c. The actual Second Lowest Cost Silver Plan (SLCSP) premium under the waiver and an estimate of the SLCSP premium as it would have been without the waiver, for a representative consumer (e.g., a 21-year old non-smoker) in each rating area.
- 2) Changes to MGARA or other program changes as specified in STC 2.
- 3) Notification of changes to state law that may impact the waiver as specified in STC 2.
- 4) Reporting of:
 - a. Federal pass-through funding spent on reinsurance claim payments to issuers from MGARA and/or operation of the reinsurance program.
 - b. The unspent balance of federal pass-through funding for the reporting year, if applicable.
- 5) The amount of state funding from issuer assessments available to fully fund MGARA for the reporting year.
- 6) A description of any incentives for providers, enrollees, and plan issuers to continue managing health care cost and claims for individuals eligible for reinsurance.
- 7) A report on the reconciliation (if any) of reinsurance payments that are duplicative of reimbursement through the HHS-operated risk adjustment program high-cost risk pooling mechanism. The report should include the MGARA reinsurance payment (before reconciliation) for high-cost claims to issuers who also receive payment through the HHS risk adjustment program under the high-cost risk pooling mechanism, the risk adjustment amount paid by HHS for those claims, and the reinsurance true-up amount applied.

Payment Schedule: The state will inform the Departments of the MGARA payment schedule by January 1, 2019.

Quarterly and other Reports: Under 31 CFR §33.120(b), 45 CFR §155.1320(b), and 45 CFR §155.1324(a), the state must conduct periodic reviews related to the implementation of the waiver. The state will submit a report to the Departments on the operation of MGARA, including the plan for processing claims, by February 28, 2019. Thereafter, the state must report on the operation of the waiver quarterly, including, but not limited to reports of any ongoing operational challenges and plans for and results of associated corrective actions, no later than 60

days following the end of each calendar quarter. The state can submit their annual report in lieu of their fourth quarter report.

11. Post Award Forum. Per 31 CFR §33.120(c) and 45 CFR §155.1320(c), within six months of the waiver's effective date and annually thereafter, the state will afford the public an opportunity to provide meaningful comment on the progress of the waiver. The state is required to publish the date, time and location of the public forum in a prominent location on the state's public web site at least 30 days prior to the date of the planned public forum. The state must also include a summary of this forum as part of the quarterly report for the quarter in which the forum was held and the annual report as required under 31 CFR §33.124 and 45 CFR §155.1324 as specified in STC 10.

12. Monitoring Calls. The state must participate in monitoring calls with the Departments that are deemed necessary by the Departments. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the waiver. Areas to be addressed include the impact on the regulatory criteria discussed above and state legislative or policy changes. The Departments will update the state on any federal policies and issues that may affect any aspect of the waiver. The state and the Departments will jointly develop the agenda for the calls. It is anticipated that these calls will occur at least semi-annually.

13. Federal Evaluation. The Departments will evaluate the waiver using federal data, state reporting, and the application itself to ensure that the Secretaries of the Departments can exercise appropriate oversight of the approved waiver. Per 31 CFR §33.120(f) and 45 CFR §155.1320(f), if requested by the Departments, the state must fully cooperate with the Departments or an independent evaluator selected by the Departments to undertake an independent evaluation of any component of the waiver. As part of this required cooperation, the state must submit all requested data and information to the Departments or the independent evaluator. The Departments will consider the evaluation costs to the federal government in the deficit neutrality assessment and, if necessary, take them into account in the pass-through funding calculation.

14. Pass-through Funding. Under section 1332(a)(3) of the PPACA, the state will be entitled to funding based on the amount of premium tax credits (PTC) that would have been provided to individuals under section 36B of the Internal Revenue Code in the State of Maine absent the waiver, but that will not be provided under the waiver, reduced, if necessary, to ensure deficit neutrality as required by the section 1332(b)(1)(D). The Departments have evaluated the estimates in the application for a pass-through amount for the period of the waiver. The state will receive pass-through funding for the purpose of implementing the state plan under the waiver. Pass-through amounts will be made available in advance of MGARA payments to the insurer(s) and no later than April of the applicable calendar year.

Starting with the 2019 plan year and for each plan year thereafter, on or before September 15th of the year preceding the plan year, the state will provide to the Departments: (1) the final second lowest cost silver plan (SLCSP) rates for a representative individual (e.g. a 21 year old non-smoker) in each rating area; and, (2) the state's estimate of what the final SLCSP rates for a representative individual in each rating area would have been absent approval of this waiver. By the same dates, the state also will provide (3) the total amount of all premiums expected to be

paid in the non-group market for the plan year; and, (4) what total premiums would have been for the plan year without the waiver. The state will include with this information the methods and assumptions the state used to estimate the final SLCSP rates for each rating area absent approval of this waiver.

The amount of pass-through funding for plan year 2019 will be communicated to the state no later than October 31, 2018, conditional on receipt of items 1 through 4 in the paragraph above by the date specified above, and subject to a final administrative determination by the Department of Treasury prior to payment. The pass-through amount for plan years 2020 through 2023 will be calculated by the Departments annually (per PPACA section 1332(a)(3)) and reported to the state not later than October 31 of the preceding year, conditional on receipt of the SLCSP premium and total premium information (items 1 through 4 above) by September 15.

The pass-through funds cannot be obligated by the state prior to the waiver effective date. The state agrees to use the full amount of pass-through funding for purposes of implementing the state's plan as approved by the Departments, including implementing MGARA for 2019 and future years. Moreover, to the extent pass-through funding exceeds the amount necessary for the reinsurance program to cover payments for individual claim payments to issuers under MGARA and/or operation of the reinsurance program, the remaining funds must be carried forward and used for purposes of implementing the state's plan under the waiver, such as making reinsurance payments in the next calendar year.

If the waiver is not extended, unused pass-through funds will be recovered promptly following the end of the approved waiver period, December 31, 2023. The state will comply with all necessary steps to facilitate the recovery within a prompt timeframe.

15. The Departments' Right to Amend, Withdraw, Terminate or Suspend. Under 31 CFR §33.120(d) and 45 CFR §155.1320(d), the Departments reserve the right to amend, withdraw, terminate, or suspend the waiver (in whole or in part) at any time before the date of expiration, if the Departments determine that the state has materially failed to comply with these STCs or if the state fails to meet the specific statutory requirements or "guardrails" related to coverage, affordability, comprehensiveness, or deficit neutrality.

a) The Departments will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

b) In the event that all or a portion of the waiver is terminated or suspended by the Departments or if all or a portion of the waiver is withdrawn, federal funding available after the effective date of the termination, suspension, or withdrawal will be limited to normal closeout costs associated with an orderly termination, suspension or withdrawal, including service costs during any approved transition period and administrative costs of transitioning participants, as described in 31 CFR §33.120(e) and 45 CFR §155.1320(e).

c) Unused pass-through funding will be recovered. The state will comply with all necessary steps to facilitate the recovery within a prompt timeframe.

Eric Cioppa
Superintendent
Maine Bureau of Insurance
State of Maine

Date: _____

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services

Date: _____

David Kautter
Assistant Secretary for Tax Policy
U.S. Department of the Treasury

Date: _____



MAINE BUREAU OF INSURANCE
2019 Individual and Small Group Health
Insurance Rate Filings

Individual Rate Filings 2019			
Companies	With MGARA		
	Avg. Rate Incr.	Min	Max
Anthem	-4.3%	-	3.0%
Community Health Options	0.9%	-	3.66%
Harvard-HMO	2.1%	-4.4%	3.6%

These rates are the final rates approved by the Maine Bureau of Insurance.

All rates listed are **average** rate increases across all plans, by each insurer.

Information about MGARA (Maine Guaranteed Access Reinsurance Association) and Maine's 1332 State Innovation Waiver application to the Centers for Medicare & Medicaid and can be found at <http://www.maine.gov/pfr/insurance/mgara/index.htm>.

Small Group Rate Filings 2019			
Companies	With MGARA		
	Avg. Rate Incr.	Min	Max
Aetna Health	12.1%	5.0%	21.0%
Aetna Life	7.0%	0.0%	8.1%
Anthem	11.0%	4.2%	19.3%
Community Health Options	8.4%	5.2%	13.8%
Harvard and HPHC	14.8%	5.1%	20.4%
United Healthcare	2.2%	-8.5%	13.2%



Maine Department of Health and Human Services
Commissioner's Office
11 State House Station
221 State Street
Augusta, Maine 04333-0011

PAUL R. LePAGE
GOVERNOR

BETHANY L. HAMM
ACTING COMMISSIONER

Sent via e-mail

September 4, 2018

Richard R. McGreal, Associate Regional Administrator
Department of Health and Human Services
Centers for Medicare and Medicaid Services
JFK Federal Bldg., Government Center
Room 2275
Boston, Massachusetts 02203

RE: TN No. 18-0006, 18-0007

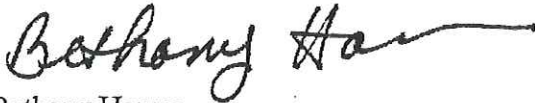
Dear Mr. McGreal:

Submitted for CMS review via the official State Plan Amendment MACPRO Portal, pursuant to an order of a state trial court dated June 4, 2018, is the State Plan Amendment (SPA) 18-0006 and 18-0007, regarding expansion of eligibility for MaineCare under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, for individuals making up to 133% of the federal poverty level. Though funds have not been legislatively appropriated for this expansion—and the state courts have yet to issue a final order on whether the Department can legally be required to fund the State's share of any projected expenses without an appropriation—submission of this SPA at this time is required by the state trial court's order.

Attached to this cover letter is a correspondence sent to Secretary Azar and Administrator Verma outlining our significant concerns about the submission of this SPA. In addition to the concerns noted in that letter, I would like to note that while we checked the box signifying provision of notification to the Tribes in Maine, that notification did not meet the 30-day notification requirement outlined in our current State Plan and our MACPRO submission would not go through without a tribal notice date in the past. For that reason, MACPRO reflects a tribal notice date of September 3, 2018, whereas our actual notice date uses September 4, 2018. In addition, I cannot overemphasize the risk that the approval of this SPA will place on existing populations based on the fact that our existing budget will be utilized to cover all populations—old and new.

If you have any questions, please contact Stefanie Nadeau, Director, Office of MaineCare Services at 207-287-2093.

Sincerely,



Bethany Hamm
Acting Commissioner
Maine Department of Health and Human Services

CC:

Alex M. Azar II, Secretary, US Department of Health and Human Services
Seema Verma, Administrator, Centers for Medicaid and Medicare Services
Holly Lusk, Chief of Staff/Legislative Director, Governor's Office
Madeline Malisa, Chief Counsel, Governor's Office
Stefanie Nadeau, Director, Office of MaineCare Services
Patrick Strawbridge, Consovoy McCarthy Park PLLC

Attachments:

A cover letter to your attention
Transmittal Form 179 for Maine's FMAP Claiming SPA
Supplement 18 to attachment 2.6A
Table 1 from Part 2 of the MAGI Conversion Plan.
Tribal Notice dated September 4, 2018.
A Letter from Governor LePage to Secretary Azar, dated August 31, 2018.

CMS-10434 OMB 0938-1188

Package Information

Package ID ME2018MS00090
Program Name N/A
SPA ID ME-18-0006
Version Number 1
Submitted By Esther Bullard

Submission Type Official
State ME
Region Boston, MA
Package Status Submitted
Submission Date 9/4/2018
Regulatory Clock 90 days remain
Review Status Review 1

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | ME2018MS00090 | ME-18-0006

Package Header

Package ID	ME2018MS00090	SPA ID	ME-18-0006
Submission Type	Official	Initial Submission Date	9/4/2018
Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	N/A		

State Information

State/Territory Name: Maine Medicaid Agency Name: Office of MaineCare Services

Submission Component

- State Plan Amendment
- Medicaid
- CHIP

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | ME2018MS00090 | ME-18-0006

Package Header

Package ID ME2018MS00090
 Submission Type Official
 Approval Date N/A
 Superseded SPA ID N/A

SPA ID ME-18-0006
 Initial Submission Date 9/4/2018
 Effective Date N/A

SPA ID and Effective Date

SPA ID ME-18-0006

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Financial Eligibility Requirements for Non-MAGI Groups	9/4/2018	
Mandatory Eligibility Groups	9/4/2018	
Adult Group	9/4/2018	

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | ME2018MS00090 | ME-18-0006

Package Header

Package ID	ME2018MS00090	SPA ID	ME-18-0006
Submission Type	Official	Initial Submission Date	9/4/2018
Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	N/A		

Executive Summary

Summary Description Including Goals and Objectives Establish a coverage group for adults between the ages of 21 and 64 who do not otherwise have a coverage group (formerly CMS form S32).

The effective date of coverage remains an unresolved issue of dispute in state court. The applicant believes in no circumstance should any SPA be approved for a period not covered by an adequate appropriation of funds, and requests that CMS work with the state to update the proper effective date in the event the SPA is approved. The fiscal impact described below reflects an effective date of September 4, 2018.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2018	\$0
Second	2019	\$495418267

Federal Statute / Regulation Citation

1902(a)(10)(A)(i)(VIII)
42 CFR 435.119

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | ME2018MS00090 | ME-18-0006

Package Header

Package ID ME2018MS00090
 Submission Type Official
 Approval Date N/A
 Superseded SPA ID N/A

SPA ID ME-18-0006
 Initial Submission Date 9/4/2018
 Effective Date N/A

Governor's Office Review

- No comment
- Comments received
- No response within 45 days
- Other

Describe Please incorporate by reference the letter Governor Paul R. LePage sent to Secretary Azar and Administrator Verma on August 31, 2018.

Submission - Public Comment

MEDICAID | Medicaid State Plan | Eligibility | ME2018MS00090 | ME-18-0006

Package Header

Package ID ME2018MS00090	SPA ID ME-18-0006
Submission Type Official	Initial Submission Date 9/4/2018
Approval Date N/A	Effective Date N/A
Superseded SPA ID N/A	

Indicate whether public comment was solicited with respect to this submission.

- Public notice was not federally required and comment was not solicited
- Public notice was not federally required, but comment was solicited
- Public notice was federally required and comment was solicited

Submission - Tribal Input

MEDICAID | Medicaid State Plan | Eligibility | ME2018MS00090 | ME-18-0006

Package Header

Package ID ME2018MS00090
 Submission Type Official
 Approval Date N/A
 Superseded SPA ID N/A

SPA ID ME-18-0006
 Initial Submission Date 9/4/2018
 Effective Date N/A

One or more Indian health programs or Urban Indian Organizations furnish health care services in this state

- Yes
- No

This state plan amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations

- Yes
- No

The state has solicited advice from Indian Health Programs and/or Urban Indian Organizations, as required by section 1902(a)(7)(B) of the Social Security Act, prior to submission of this SPA

Complete the following information regarding any solicitation of advice and/or tribal consultation conducted with respect to this submission:

Solicitation of advice and/or Tribal consultation was conducted in the following manner:

- All Indian Health Programs

Date of solicitation/consultation:	Method of solicitation/consultation:
9/3/2018	Letter via email

- All Urban Indian Organizations

States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:

- All Indian Tribes

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Name	Date Created
Tribal Notice 18-0006	9/4/2018 10:35 AM EDT

Indicate the key issues raised (optional)

- Access
- Quality
- Cost
- Payment methodology
- Eligibility
- Benefits
- Service delivery
- Other issue

Medicaid State Plan Eligibility

Financial Eligibility Requirements for Non-MAGI Groups

MEDICAID | Medicaid State Plan | Eligibility | ME2018MS00090 | ME-18-0006

Package Header

Package ID	ME2018MS00090	SPA ID	ME-18-0006
Submission Type	Official	Initial Submission Date	9/4/2018
Approval Date	N/A	Effective Date	9/4/2018
Superseded SPA ID	N/A		

The state applies the following financial methodologies for all eligibility groups whose eligibility is not based on modified adjusted gross income (MAGI) rules (described in 42 C.F.R. 5435.603):

A. Financial Eligibility Methodologies

The state determines financial eligibility consistent with the methodologies described in 42 C.F.R. 5435.601.

B. Eligibility Determinations of Aged, Blind and Disabled Individuals

Eligibility is determined for aged, blind and disabled individuals based on one of the following:

SSA Eligibility Determination State (1634 State)

The state has an agreement under section 1634 of the Social Security Act for the Social Security Administration to determine Medicaid eligibility of SSI beneficiaries. For all other individuals who seek Medicaid eligibility on the basis of being aged, blind or disabled, the state requires a separate Medicaid application and determines financial eligibility based on SSI income and resource methodologies.

State Eligibility Determination (SSI Criteria State)

The state requires all individuals who seek Medicaid eligibility on the basis of being aged, blind or disabled, including SSI beneficiaries, to file a separate Medicaid application, and determines financial eligibility based on SSI income and resource methodologies.

State Eligibility Determination (209(b) State)

The state requires all individuals who seek Medicaid eligibility on the basis of being aged, blind or disabled, including SSI beneficiaries, to file a separate Medicaid application, and determines financial eligibility using income and resource methodologies more restrictive than SSI.

C. Financial Responsibility of Relatives

The state determines the financial responsibility of relatives consistent with the requirements and methodologies described in 42 C.F.R. 5435.602.

D. Additional Information (optional)

Medicaid State Plan Eligibility

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | ME2018MS00090 | ME-18-0006

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Mandatory Coverage

A. The state provides Medicaid to mandatory groups of individuals. The mandatory groups covered are:

Families and Adults

Eligibility Group Name	Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Infants and Children under Age 19	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	CONVERTED
Parents and Other Caretaker Relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	CONVERTED
Pregnant Women	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	CONVERTED
Deemed Newborns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Former Foster Care Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Transitional Medical Assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Extended Medicaid due to Spousal Support Collections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW

Aged, Blind and Disabled

Eligibility Group Name	Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
SSI Beneficiaries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Individuals Receiving Mandatory State Supplements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Individuals Who Are Essential Spouses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Institutionalized Individuals Continuously Eligible Since 1973	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Blind or Disabled Individuals Eligible in 1973	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package ②	Included in Another Submission Package	Source Type ②
Individuals Who Lost Eligibility for SSI/SSP Due to an Increase in OASDI Benefits in 1972	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA Increases since April, 1977	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Disabled Widows and Widowers Ineligible for SSI due to Increase in OASDI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Working Disabled under 1619(b)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Disabled Adult Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Qualified Medicare Beneficiaries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Qualified Disabled and Working Individuals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Specified Low Income Medicare Beneficiaries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Qualifying Individuals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | ME2018MS00090 | ME-18-0006

Package Header

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B. The state elects the Adult Group, described at 42 C.F.R. §435.219.

Yes No

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package <input checked="" type="checkbox"/>	Included In Another Submission Package	Source Type <input checked="" type="checkbox"/>
Adult Group	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NEW

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Adult Group

MEDICAID | Medicaid State Plan | Eligibility | ME2018MS00090 | ME-18-0006

Non-pregnant individuals age 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL

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The state covers the Adult Group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Have attained age 19 but not age 65
2. Are not pregnant
3. Are not entitled to or enrolled for Part A or B Medicare benefits
4. Are not otherwise eligible for and enrolled for mandatory coverage under the state plan in accordance with 42 CFR 435, subpart B.

B. Financial Methodologies

MAGI-based methodologies are used in calculating household income. Please refer as necessary to MAGI-Based Methodologies, completed by the state.

C. Income Standard Used

The amount of the income standard for this group is 133% FPL.

D. Coverage of Dependent Children

Parents or caretaker relatives living with a child under the age specified below are not covered unless the child is receiving benefits under Medicaid, CHIP or through the Exchange or otherwise enrolled in minimum essential coverage, as defined in 42 CFR 435.4.

- 1. Under age 19, or
- 2. A higher age of children, if any covered under the Reasonable Classifications of Children eligibility group (42 CFR 435.222) on March 23, 2010:
 - a. Under age 20
 - b. Under age 21

Adult Group

MEDICAID | Medicaid State Plan | Eligibility | ME2018MS00090 | ME-18-0006

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E. Additional Information (optional)

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Paul R. LePage
 GOVERNOR

August 31, 2018

Secretary Alex M. Azar II
 U.S. Department of Health and Human
 Services
 200 Independence Avenue, S.W.
 Washington, D.C. 20201

Seema Verma, Administrator
 Centers for Medicaid and Medicare Services
 7500 Security Boulevard
 Baltimore, MD 21244
 And via email: seema.verma@cms.hhs.gov

Dear Secretary Azar and Administrator Verma,

I strongly encourage CMS to reject the State Plan Amendment (SPA) that may soon be submitted by the Maine Department of Health and Human Services (DHHS) pursuant to court order. If accepted, the SPA would commit Maine to expanding its Medicaid program to an additional 70,000 to 90,000 individuals. However, *not one dime* of the hundreds of millions of dollars that will be needed to pay for the state's share of the expansion has been appropriated. Until funding is in place, Maine will not be able to satisfy the commitments to the federal government that it would be making if the SPA were accepted. For these and other reasons described below, I encourage you to reject the SPA.

* * *

On November 7, 2017, Maine voters approved a referendum to expand the state's Medicaid program to cover individuals under age 65 with incomes at or below 138% of the federal poverty level. The referendum, however, contained no appropriations or any other method of funding to pay for this expansion (presumably because the proponents concluded that voters would have been less likely to support the referendum if it were accompanied by new taxes or fees). Nor did the referendum provide funding for DHHS to hire the approximately 100 additional employees who would be needed to implement the expansion.

Rather than including a dedicated funding mechanism (or *any* funding mechanism), the referendum instead left the necessary funding decisions to the ordinary legislative process. The Fiscal Impact Statement accompanying the referendum estimated that the Medicaid expansion would require net annual appropriations of approximately \$55 million, and that "*additional implementing legislation will be required* to provide the additional appropriations and allocations." Even those fiscal estimates were too low (despite consistent arguments by Democrats that Medicaid expansion is free or results in savings). An analysis prepared by DHHS in January 2018 found that the state's share of Medicaid funding for the expanded population would require an expenditure of approximately \$452 million between 2018 and 2023 and more than \$100 million



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per year thereafter. Current Department projections indicate that the balance in Maine's Medicaid accounts will not even be sufficient to cover the costs of Medicaid for the State's *existing* population for the remainder of this fiscal year.

Shortly after the referendum was approved, I acknowledged that Medicaid expansion was now the law and asked the Legislature to identify a way to pay for the substantial additional costs the state would incur. I informed the Legislature that whatever method it chose should be fiscally prudent and sustainable in the long run (Maine has an unfortunate history of funding major programs through budget gimmicks or one-time funding that is insufficient to cover long-term costs). I even suggested some funding sources, but the Legislature chose not to accept my suggestions. To date, *no necessary appropriations exist*, and there is no timetable for when such funding might materialize. As a result, I instructed DHHS not to begin implementing the costly expansion until the necessary staff and appropriations are in place. An activist state trial court has nonetheless ordered DHHS to submit the SPA to the federal government, and I have been unable to obtain appellate review on the merits of that decision. That decision ordered the submission of the SPA, but did not order or even suggest a source of funding—a function that even the court did not dispute belongs exclusively to the Legislature.

Although the Maine courts have ordered DHHS to submit the SPA to CMS despite the lack of necessary funding, CMS is under no obligation to approve it. Indeed, doing so would *violate* federal law, as the Chief Justice of the Maine Supreme Judicial Court noted in a recent decision by the Court declining, for now, to consider an appeal from the current order. As the Chief Justice explained, “any plan submitted by [DHHS] will, by definition, have to report candidly that no legislative action or judicial adjudication regarding funding has been completed” and thus “such a plan appears to have no reasonable likelihood of meeting the approval of the administrators of the federal Medicaid program.” *Maine Equal Justice Partners v. Comm’r, Maine Dep’t. Health & Hum. Servs.*, 2018 ME 127, ¶ 17 (Saufley, C.J., concurring); *see also id.* ¶ 14 n.5 (noting that Maine’s “submission cannot, in practical terms, meet the requirements of the federal law at this stage of the trial court’s proceeding” (citing 42 U.S.C. § 1396a(a)(2)). *See also* 42 C.F.R. Part 431.

The court-mandated SPA runs afoul of other federal requirements as well. The failure of the Legislature to provide any funding for additional staff leaves DHHS in serious jeopardy of being unable to meet its obligations to accurately make eligibility and program integrity determinations. *See* 42 C.F.R. § 431.960(d); 42 C.F.R. § 431.1010. Recent audits from the HHS Office of Inspector General indicate this has been a serious issue in states that expanded Medicaid with a legislative commitment of funding.¹ Moreover, because the SPA is being submitted according to the terms of a court order, the Department has been unable to comply with the mandatory notice provisions (including 30-day notice) to Indian tribes. *See* 42 C.F.R. §431.408; Tribal Consultation Policy (Dec. 10, 2015).²

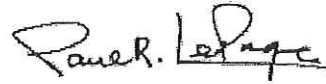
¹*See, e.g.,* *OIG Audit of California* (February 2018) (<https://oig.hhs.gov/oas/reports/region9/91602023.pdf>); *OIG Audit of California* (January 2018) (<https://oig.hhs.gov/oas/reports/region2/21501015.pdf>).

² *See* <https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/CMSTribalConsultationPolicy2015.pdf>.

* * *

I thus strongly encourage CMS to reject the SPA. If the SPA is approved, the state will become obligated under federal law to fund the full range of Medicaid services for tens of thousands of additional individuals. Until the necessary funding is in place, however, the federal government can take no assurance that Maine will be able to pay for its share of costs under the program. Under these circumstances, CMS should reject the SPA and avoid putting Maine in a situation where it will be unable to meet its obligations to the federal government. Indeed, prior unfunded expansions left Maine deeply in debt—hospital providers were owed nearly a billion dollars in Medicaid money by the time my administration paid them several years ago. CMS should not accept a SPA in circumstances in which the state has no legislative commitment ensuring that it can comply with its obligations.

Respectfully submitted,



Paul R. LePage
Governor

cc: President Donald J. Trump
Vice President Michael R. Pence

