# Medicaid Oversight and Advisory Committee

### Minutes

### <MeetMDY1> December 13, 2017

**Call to Order and Roll Call**

The<MeetNo2> Medicaid Oversight and Advisory Committee meeting was held on<Day> Wednesday,<MeetMDY2> December 13, 2017, at<MeetTime> 1:30 PM, in<Room> Room 131 of the Capitol Annex. Representative Kimberly Poore Moser, Chair, called the meeting to order, and the secretary called the roll.

Present were:

Members:<Members> Representative Kimberly Poore Moser, Co-Chair; Senator Morgan McGarvey; and Representative Melinda Gibbons Prunty.

Guest Legislators: Representatives Ken Fleming and C. Wesley Morgan.

Guests: Steve Miller, Commissioner, Jill Hunter, Deputy Commissioner, and Donna Little, Senior Policy Advisor, Department for Medicaid Services, Cabinet for Health and Family Services; Rosemary C. Smith, R.Ph., Co-Founder, Kentucky Independent Pharmacist Alliance, Jordan Drug, Inc.; Trevor Ray, PharmD, Midway Pharmacy, Independent Pharmacist; Dr. Robert Couch, MD, Emergency Physician; Chris Callis, Systems Director, Physician Contracting, Baptist Healthcare System, Inc.; Luther Smith, Kentucky Independent Pharmacist Alliance, Jordan Drug, Inc.; Frank Miller, Jr., Gateway Health; Tori Ames, Cincinnati Children's Hospital Medical Center; Kelli Williams, Accenture; Annette Gervais, Kentucky Home Care Association; Koleen Slusher, Director, Department for Behavioral Health, Developmental and Intellectual Disabilities, Cabinet for Health and Family Services; Trudi Matthews, Managing Director, Kentucky Regional Extension Center, University of Kentucky; Neville Wise, Assistant Director, Revenue Management, University of Kentucky; Sarah S. Nicholson, Kentucky Hospital Association; and Nancy Galvagni, Kentucky Hospital Association.

LRC Staff: Jonathan Scott, Chris Joffrion, and Becky Lancaster.

**2017 Department for Medicaid Services Budget and 2018 Session Budget**

Steve Miller, Commissioner, Department for Medicaid Services (DMS), Cabinet for Health and Family Services (CHFS), stated that the Centers for Medicare and Medicaid Services (CMS) is close to approving the 1115 Kentucky HEALTH Waiver. DMS has approximately 1,414,000 participating members in Kentucky Medicaid including 456,000 children. There are 40,700 enrolled providers in Kentucky Medicaid. Kentucky Medicaid has an $11 billion budget. The Medicaid Expansion in 2014 was proposed and budgeted with expectations of adding 180,000 members by 2021. There has been approximately 480,000 members added to the Medicaid program. The current Managed Care Organizations (MCOs) contract extension is through June 30, 2018. All MCOs are subject to 90 percent Medical Loss Ratio (MLR). In 2015, the MCOs underwriting ratio or profit was 11.3 percent and in 2016, the MCOs underwriting ratio was 2.5 percent.

DMS mandated, as part of the Affordable Care Act (ACA), coverage of the 10 Essential Health Benefits and to align with Kentucky’s Benchmark Plan as determined by Department of Insurance. DMS aligned benefit packages into one plan for both expansion and traditional populations. Ninety percent of Medicaid enrollees in Kentucky are covered by one of the five MCOs and 10 percent of the enrollees are covered using the fee-for-service program. State funding for the two year budget cycle that ended in June of 2016 was approximately $3.1 billion. For the two year budget cycle that will end in June of 2018, the state will spend approximately $3.65 billion. The total expenditures of the state and federal money combined in the 2018 budget will be over $11 billion. Seventy percent, or $7.2 billion, of the budget is spent on managed care. In 2017, the average cost per beneficiary per member per month was $600.83.

Jill Hunter, Deputy Commissioner, Department for Medicaid Services, Cabinet for Health and Family Services, stated that the administration costs in Kentucky Medicaid continue to rise as the number of enrollees increase. DMS spent approximately 1.53 percent of every dollar received on administration costs, salaries, and supplies in state fiscal year (SFY) 2017. DMS is working daily to prepare for the 1115 Kentucky HEALTH Waiver. The entire benefit program with authorization from CMS will move forward in July of 2018. The Office of Administrative and Technology Services (OATS) team is working on the development and implementation of a Medicaid enterprise management system (MEMS). DMS is developing an electronic visit verify (EVV) system as mandated by federal law in the 21st Century Cures Act.

Commissioner Miller stated that the federal government pays 100 percent of the Children’s Health Insurance Program (CHIP) however, federal funds have not been reissued as of October 1, 2017. Kentucky had a surplus in the CHIP grant funds from the previous year and expects coverage of CHIP through March 10, 2018.

**Medicaid Emergency and Specialty Coverage in Communities Situated with Multi-State Borders**

Deputy Commissioner Hunter stated that a Medicaid member with a medical emergency who is traveling or has crossed state lines should seek care at the closest facility. Out-of-state emergency care is covered. Medicaid does allow out-of-state providers to enroll in most provider types. Out-of-state providers must be enrolled to receive reimbursement. CMS does not allow DMS to reimburse any provider not enrolled with Medicaid. Out-of-state providers are subject to the same reimbursement and participation requirements as in-state providers.

In response to questions from Representative Gibbons Prunty, Commissioner Miller stated that if the Medicaid expansion did not happen there could possibly be about 900,000 people in the program. The 1115 Kentucky HEALTH Waiver would help able-bodied adults transition off Medicaid and go to commercial insurance. DMS has projected that, over five years, 85,000 members would be able to transition off of Medicaid and move to commercial insurance.

**Prefiled Legislation**

**BR 127, AN ACT** relating to service delivery improvements in managed care networks, sponsored by Representative Ken Fleming.

Representative Fleming summarized BR 127, which deals with the provider credentialing processes within the Kentucky Medicaid system. MCOs take 90 to 180 days to credential providers. BR 127 would centralize the credentialing process to a single verification organization managed by DMS. He hopes to reduce the credentialing timeframe to 45 days. BR 127 has an exception that will allow hospitals to continue with existing credentialing procedures. BR 127 includes a provision to require the MCOs personnel to be available eight hours a day and five days a week for authorizations and claims. BR 127 would require MCOs to respond to any claim or grievances submitted by providers within a 30 day timeframe.

Dr. Robert Couch, MD, Emergency Physician, testified that within his group of physicians and staff a large amount of time, energy, and resources are spent preforming non-clinical activities. The activities are required by the payors before the physicians can see patients or receive reimbursements for the services rendered. The administrative duties increase costs for the patients and the businesses. Credentialed providers may participate in that particular MCO’s network. The provider will have to negotiate a business contract and complete the enrollment process with Medicaid and the MCOs. It routinely takes a provider six months or longer to get credentialed which creates a problem because many MCOs have a six month claim limit. If a new physician who is not credentialed writes a prescription for a Medicaid patient, the prescription cannot be filled by the pharmacy and Medicaid cannot pay for the prescription.

Chris Callis, Systems Director, Physician Contracting, Baptist Healthcare System, Inc., stated that his experience with credentialing is on the administrative side of the process. Many providers trying to complete the credentialing process have gone beyond a 180 day timeframe. BR 127 will expedite the credentialing process and improve the provider’s ability to deliver healthcare to communities in a more timely fashion without the burden of additional administration expense and effort.

**BR 173,** **AN ACT** relating to public assistance, sponsored by Representative C. Wesley Morgan.

Representative Morgan summarized BR 173, which relates to drug testing recipients of public assistance programs. He gave an example of how drug testing helped to resolve issues within his businesses. Approximately 15 states have passed similar legislation. The drug testing could also include unemployment insurance recipients. Individuals on public assistance could receive job training or begin working to commence paying into the system.

In response to questions from Representative Moser, Representative Morgan stated that he left the language open for the secretary of CHFS to make the policy regarding individuals who are in treatment for substance use disorders. He does not object to individuals who test positive for drugs and enroll in a substance abuse program returning to work.

In response to questions from Senator McGarvey, Representative Morgan stated that there have been approximately 15 states to pass similar laws. Available data that is indicates there is only a small percentage of benefit to the states. The law has given states the right to drug test, but the implementation of the law has caused debate in other states. A sunset provision may be added to BR 173 to allow the legislature to review and update the bill. He does not want to test public assistance recipients for the use of alcohol.

**BR 216, AN ACT** relating to pharmacy benefits in the Medicaid program, sponsored by Senator Max Wise.

Rosemary Smith, Owner, Jordan Drug, Kentucky Independent Pharmacist Alliance (KIPA), stated that there has been reimbursement changes and unsustainable cuts to pharmacy reimbursements by the Pharmacy Benefit Managers (PBMs) in the Kentucky Medicaid program. She has received an email and letter from CVS Caremark, also a PBM in Kentucky, seeking to purchase her independent pharmacy businesses. Independent pharmacies have been cut significantly since managed care was put into place. There has been under-reimbursement of drug costs by PBMs to move Medicaid members to mail-order pharmacies. About 85 percent of her prescription reimbursements are being set by her competitor, who is also the PBM in four of the five MCOs. She has sent surveys to KIPA members to gather information regarding the number of independent pharmacy closings due to under-reimbursement. West Virginia has moved pharmacy benefits out of managed care and back to the state Medicaid department, saving the taxpayers millions of dollars. Ohio has faced almost identical issues of under-reimbursement costs with Medicaid PBMs. Ohio, similar to Kentucky, has five MCOs, and four of which have the same PBM--CVS Caremark.

Trevor Ray, PharmD, Midway Pharmacy, Independent Pharmacist, stated that an independent pharmacy in Hardin County closed specifically due to under-reimbursement. In rural areas, pharmacy closures can become an access problem for members. The 90 percent MLR required of MCOs is not required of the PBMs. The MLR not extending to the PBMs makes it difficult to do a strict analysis to know how much money is being lost by the state as PBM profit. If the pharmacy benefit management is returned to DMS, the state can do a cost analysis and DMS can retain the money that could have been profited by PBMs. Kentucky has an opportunity to be proactive, get ahead of the problem, and prevent destruction of the independent pharmacies.

**Adjournment**

There being no further business, the meeting was adjourned at 3:03 PM.