MEDICAID OVERSIGHT AND ADVISORY COMMITTEE

Minutes

July 18, 2018

Call to Order and Roll Call

The Medicaid Oversight and Advisory Committee meeting was held on Wednesday, July 18, 2018, at 1:30 PM, in Room 131 of the Capitol Annex. Senator Ralph Alvarado, Chair, called the meeting to order at 1:36 PM, and the secretary called the roll.

Present were:

Members: Senator Ralph Alvarado, Co-Chair; Representative Kimberly Poore Moser, Co-Chair; Senators Danny Carroll, Morgan McGarvey, and Stephen Meredith; Representatives Jim Gooch Jr., Joni L. Jenkins, and Melinda Gibbons Prunty.

Guests: Adam Meier, Secretary, Kristi Putnam, Deputy Secretary, Cabinet for Health and Family Services; Jill Hunter, Commissioner, Alisha Clark, RN, Human Services Program Branch Manager, Steve Bechtel, Chief Financial Officer, Department for Medicaid Services, Cabinet for Health and Family Services; Jason Gerling, Managing Consultant, Navigant; Betsy Johnson, President, Kentucky Association of Health Care Facilities, Executive Director, Kentucky Center for Assisted Living; Jay Trumbo, Chief Financial Officer, Health Systems of Kentucky; Wayne Johnson, Vice President of Finance, Kentucky Association of Health Care Facilities and Kentucky Center for Assisted Living; Lisa Barker, Case Manager, Rankin's New Leaf Supports Case Management; Carolyn Wheeler, Power of Attorney for Linda Montgomery; Linda Montgomery, Michelle P. waiver recipient; James Bonar, waiver recipient; Gwen Bryant, waiver recipient; James Whitlock, waiver recipient; Steven Whitlock; Terri Thomas, Chief Program Officer, Harbor House of Louisville; Joseph Martin, Martin Case Management; Cheri Ellis-Reeves, Oakwood Residential Facility; Karen House, Family Intermediate Care Facility; Laura Lilly Stephens, Senior Helper; Kathy Utterback; Terry Elder, waiver recipient; Mary Ellis; Lillian Bassett, Parent Relative Organization for Oakwood Facility (PROOF); and Bill Dolan, Attorney, Kentucky Protection and Advocacy.

LRC Staff: DeeAnn Wenk, CSA and Becky Lancaster.

Changes to the Home and Community-Based Services Waiver Recipient Liability

Jill Hunter, Commissioner, Department for Medicaid Services (DMS), Cabinet for Health and Family Services (CHFS), stated that beginning August 1, 2018, all Home and Community-Based Services (HCBS) waiver program participants will be asked to pay their full patient liability in order to maintain waiver services in compliance with applicable

federal regulations. She stated that failing to pay full patient liability puts a participant's eligibility for Medicaid or waiver services at risk.

Jason Gerling, Managing Consultant, Navigant, stated that within the 1915(c) waiver application at a federal level the state has the ability to set its own formulary for establishing the post-eligibility treatment of income. The goal of the post-eligibility treatment of income is to reassess what contribution the HCBS waiver participant needs to make to DMS. States may allow the following deductions from a participant's total income when they establish that formulary; the state's maintenance allowance, an allowance for the needs of the participant's spouse and family, and an allowance for medical and remedial care needs. The remaining income after the allowances is the patient liability.

Commissioner Hunter stated that in late 2017, letters were sent to providers notifying them of impending changes regarding patient liability. In May of 2018, the DMS fiscal intermediary pulled participant data in error resulting in incorrect letters and letters sent to non-waiver participants. On June 29, 2018, DXC Technology sent corrected patient liability letters to the correct participants. The patient liability changes need to be made to ensure that DMS is compliant and the Commonwealth is able to provide waiver services.

In response to questions from Senator Alvarado, Commissioner Hunter stated that in regards to the 1915(c) waiver, DMS has been out of compliance for at least five years. DMS staff identified the issue through an internal audit. The personal liability was lower for some recipients than it should have been if the formula in Kentucky's Medicaid state plan had been correctly applied.

Lisa Barker, Case Manager, testified that one of her clients in the Supports for Community Living (SCL) waiver program has seen her patient liability payment go from $320 a month to $975 per month. The client's participant directed supports (PDS) allows the client to live on her own with a personal assistant helping her to live in the community. The increase in the payment has caused a financial hardship and if the payment is not lowered her client must choose between living in the community or paying the patient liability upcharge. The Kentucky Department for Aging and Independent Living (DAIL) encourages clients to live their own lives with services allowing them to become normalized in the community.

Carolyn Wheeler, volunteer, Power of Attorney, testifying on behalf of Linda Montgomery, stated that since 2008, Ms. Montgomery has been on the Michelle P. Waiver (MPW) program and receives a Social Security Disability Insurance (SSDI) payment from her own work record. Ms. Montgomery's patient liability was $200 a month and will rise to $1097 a month on August 1, 2018. Ms. Montgomery faces a dilemma of paying her bills or her patient liability costs. She stated that patient liability penalizes people who work because it increases the liability and is inconsistent with the Centers for Medicare & Medicaid Services (CMS) final rule that encourages people to have a life of their own in a

community. Increasing the personal needs allowance to 100 percent or 200 percent of the federal poverty level would reduce the patient liability and help people to have sufficient funds to pay the fee.

Bill Dolan, Attorney, Kentucky Protection and Advocacy, stated that there is a choice that CHFS and DMS can make to increase the personal needs allowance to allow people to live in the community and independently. He stated that Kentucky has a much higher deduction than surrounding states that use 300 percent of the federal rate for the personal needs allowance. DMS can send waivers to CMS to change the personal liability rates.

James Bonar, waiver recipient, stated that his waiver payment will increase to $1240 a month. His income is less than the $200 cap for SSDI and he cannot afford the payment increase. If he has to pay the full amount he will have to move into a retirement home or elsewhere. He would like to have the personal liability payment lowered.

In response to questions from Representative Moser, Mr. Gerling stated that based on a scan of state and federal policies, Navigant has advised CHFS of the option to expand the personal needs allowance. States have flexibility to go between the standard of 100 percent Supplemental Security Income (SSI) up to 300 percent SSI.

Gwen Bryant, waiver recipient, testified that after the incorrect letters were sent she had trouble getting information and had to make several calls to CHFS before finding answers. Her liability payment has increased from $325 to $1097 per month. She was asked to pay the June, July, and August payments by August 1, 2018. She stated that she could not afford the payment because with Medicaid she is not allowed to save more than $2000. She stated that if she could find a job accommodating her disabilities, she is not allowed to make more than $200 a month. She stated that if she has to pay the increased patient liability amount, it will force her into a nursing home.

Steven Whitlock, testifying on behalf of James Whitlock, waiver recipient, stated that the HCBS waiver home page declares the HCBS waiver program provides services and support to elderly, children, and adults with disabilities to help them to remain in or return to their homes. He stated that the 335 percent increase in the monthly liability payment is beyond his brother's means because he is on a fixed income. In the HCBS waiver process, each person goes through a screening process before being accepted, visited by a support worker monthly, and is recertified every year by an independent third party leaving no room for fraud as with other systems. If liability is increased and patients are unable to pay, they will be forced to seek refuge in nursing homes or become homeless.

Cheri Ellis-Reeves, Oakwood Residential Facility, stated that the spectrum of intellectual disabilities include the mentally retarded and non-verbal that require one on one, and 100 percent guidance for daily living. She stated that facilities provide oversight

and accountability for participants. She hopes that Oakwood would remain a long-term care (LTC) facility and not have to become a short-term only care facility.

Terry Elder, waiver recipient, stated that her liability payment went from $320 to $1146 a month and she cannot afford the increased cost. She stated that the waiver program allows her to enjoy her community, friends, and church.

Mary Ellis, testifying on behalf of Terry Elder, stated that Ms. Elder is devastated by the increase in her liability payment. Ms. Elder believes her option is to the pay the waiver and do without other services or go to a nursing facility. Ms. Elder needs special care, equipment, and medical supplies that the waiver program does not provide but she pays for out of her own money. The waiver program increase will cause her to have less than $500 a month for supplies, food, vision care, and other various bills. Ms. Ellis stated that she assists Ms. Elder seven days a week however, the Bluegrass Area Development District (BGADD) will only pay Ms. Ellis for 40 hours of care. Ms. Elder's husband lives with her, his income is added to her income but his living expenses and circumstances are not subtracted from her liability. He is not physically able to care for her and has medical issues that are not taken in account when calculating her liability payment.

In response to questions from Representative Jenkins, Commissioner Hunter stated that patient liability is supposed to be created based on dollars coming into the member. The payment is the participants' monthly responsibility. She stated that DMS will have experts review the math in individual cases similar to the cases shared in the meeting. The maintenance allowance is an allowance for the needs of the participant, spouse, family, as well as, medical and remedial care needs. DMS does have an opportunity during the waiver redesign to improve this issue. Commissioner Hunter stated that she will need to discuss and ask if the August 1, 2018 deadline for payments can be reevaluated. She stated that if a person is in a LTC facility, receiving Medicaid, and on a waiver waiting list, there is patient liability. However, if that person is on a waiver waiting list and only has regular Medicaid, there would not be an implied patient liability because the person would not be receiving waiver services.

In response to questions from Senator Carroll, Commissioner Hunter stated that DMS has been incorrectly administering the patient liability portion of the HCBS waiver. The amount that DMS would collect from the individuals was calculated incorrectly. Previously the liability payment was capped based on what the provider was reimbursed because it was tied to a primary provider. The issue was discovered approximately six months ago. Letters went out in late 2017 to providers notifying them of impending changes. In May 2018, incorrect letters were sent to people who do not receive waiver services. Those participants assumed they would have to start paying patient liability for traditional Medicaid services. In June of 2018, correction letters were sent out to all participants.

Commissioner Hunter stated that the changes will impact providers because providers may need to collect the patient liability. The changes will not impact reimbursement to the provider directly but it impacts the individuals based on their eligibility. She stated that DMS will recalculate and think about the issue when operationalizing. She agreed that this as an emergency that needs to be dealt with promptly.

In response to questions from Representative Wuchner, Commissioner Hunter stated that approximately 19,000 letters were sent to non-waiver participants. Letters of apology and explanation letters were sent by the fiscal intermediary free of charge.

In response to a question from Senator McGarvey, Commissioner Hunter stated that she has the complete support of her leadership and finding money to fund the waiver programs would help DMS.

In response a question from Representative Moser, Commissioner Hunter stated that retroactive payments in the redesign could be reconsidered.

In response to questions from Senator Alvarado, Commissioner Hunter stated that she will need to do more research to know how soon a change to the liability payment could be implemented. She stated that if there are positive things DMS can do now during redesign, the department will proceed as long as it is legal and approved by CMS.

Changes to the Kentucky HEALTH 1115 Waiver

Kristi Putnam, Deputy Secretary, Cabinet for Health and Family Services, stated that based on the June 29, 2018, legal decision, the Kentucky HEALTH 1115 waiver changes did not begin on July 1, 2018 as planned. The court ruling gave the Kentucky HEALTH team 30 hours to identify how the court ruling affected systems integration, types of healthcare coverage, and planned communications with stakeholders. The court ruling has prevented CHFS from using the My Rewards program as the legal mechanism to pay for dental and vision coverages for those beneficiaries in the Alternative Benefit Plan (ABP). The judge's order did not rule any portion of the Kentucky HEALTH 1115 waiver components to be unlawful. The judge's order removed the Kentucky HEALTH 1115 approval based on what the judge interpreted as missing from specific consideration in the approval decision--the provision of medical assistance and the impact on coverage.

The Kentucky HEALTH team is working with the Governor's office, CMS, Health & Human Services Cabinet (HHS), and Department of Justice (DOJ) toward a re-approval. No decision has been made in regards to seeking an appeal of the judge's ruling. Individuals in the ABP do not have routine dental and vision coverage. The Kentucky HEALTH website and social media pages have been updated regularly with information about how the legal ruling has effected beneficiaries, providers, and stakeholders.

Adam Meier, Secretary, Cabinet for Health and Family Services, stated that traditional Medicaid participants, the aged, blind, and disabled, were not included in Kentucky HEALTH 1115 waiver. Medicaid populations included in the Kentucky HEALTH 1115 waiver were non-disabled adults and children. Typically, CHFS has more than 30 hours to test language and get feedback but CHFS had to put language and updates immediately into the system.

In response to questions from Representative Gooch, Secretary Meier stated that he does not think the ruling had an impact on the development of the request for proposal (RFP). The contract procurement team has been working on that RFP. The number of plans administered next year will depend on the response to CHFS from the managed care organizations (MCOs) and prospective vendors.

In response to questions from Representative Jenkins, Secretary Meier stated that he signed off on a response letter to the House Minority caucus. The letter should be printed, copied, and distributed to the caucus. He stated that he would need to get clarification on the multiple copayment issue. Copayment enforcement is a separate issue, although it happened at the same time as the Kentucky HEALTH rollout. The state benefit plans already had these policies, so there are no changes to policies other than requiring that the MCOs no longer waive the copayments. Commissioner Hunter stated that anyone except the MCOs can pay the copayment. There are some restrictions around a provider paying the copayment. The provider must have a consistent policy in place.

In response to a question from Representative Moser, Secretary Meier stated that there are several federal agencies involved in making the decision on whether or not to appeal the ruling. CHFS would prefer to gain reapproval as quickly as possible to mitigate the down time and the impact of having all the systems and changes lying in wait. CHFS is hopeful that more information will be received soon but no date has been given.

In response to questions from Senator Meredith, Secretary Meier stated that CHFS has removed the voluntary nature of the pharmacy copayment. Commissioner Hunter stated that the allowable amount for a drug is based on several variables and the average wholesale price (AWP). The allowable amount is not going to change unless it is contractually related to the copayment. Secretary Meier stated that CHFS has spent less than $10 million for technology upgrades that replaced systems in multiple Cabinets' agencies and workforce boards. The increase in the rate cell is due to the mix of the projected population.

In response to questions from Senator McGarvey, Secretary Meier stated that the comment period regarding the dental and vision plans was included as part of the Kentucky HEALTH 1115 waiver comment period. CHFS moved the dental and vision plans out of the ABP to be paid for by a separate mechanism created by the waiver. There will be significant costs associated with waiver changes. Each round of eligibility notices costs

approximately $500,000 to send to members. CHFS had planned on the My Rewards program having dental and vision coverage available to ABP members. CHFS spends approximately $60 million annually on dental and vision coverage for the expansion population.

In response to a question from Representative Gibbons, Deputy Secretary Putnam stated that CHFS wants to make clear that the judge did not rule on whether community engagement was legal for Kentucky to pursue as part of Medicaid. The ruling simply set aside the approval; the components were not part of the ruling.

In response to questions from Senator Alvarado, Deputy Secretary Putnam stated that there are approximately 460,000 people in the ABP, of which about 373,000 do not have access to routine dental and vision care. Secretary Meier stated that if the waiver is fully initiated then the My Rewards funding would be instituted and the dental and vision coverage would return.

Overview of Long-Term Care Programs

Betsy Johnson, President, Kentucky Association of Health Care Facilities (KAHCF), Executive Director, Kentucky Center for Assisted Living, stated that KAHCF is the primary association that represents propriety and nonproprietary nursing facility providers, personal care homes, and assisted living communities. Nursing facility providers are responsible for generating almost 42,000 direct jobs statewide. Medicaid accounts for 56 percent of the nursing facility revenue and 69 percent of the nursing facility residents. Kentucky has one of the highest acuity levels in long-term care in the United States.

Jay Trumbo, Chief Financial Officer, Health Systems of Kentucky, stated that Kentucky nursing facility providers have faced unprecedented general and professional liability costs due to predatory trial attorney practices. Obtaining a qualified workforce has become more difficult with the low unemployment rates and the competition in other health care fields. The loss rate is defined as the amount per occupied bed required to settle, defend, or litigate claims within a year. Kentucky has shown an increased loss rate over the past 10 years. These costs, absorbed by nursing facilities, take away dollars that could otherwise be used for patient care. The wage costs have steadily increased over the past 10 years for registered nurses (RN), licensed practical nurses (LPN), and nurse aides in nursing facilities. Medicaid inflationary increases have not kept pace with these and other staff increases.

Wayne Johnson, Vice President of Finance, Kentucky Association of Health Care Facilities, Kentucky Center for Assisted Living, stated that the urban and rural prices are adjusted quarterly for acuity and annually by an inflationary adjustment determined by DMS. Nursing providers have been paid one-tenth of one percent inflation for the past four years. A proposal by KAHCF assumed that the entire tax increase and federal match be used to pay for the proposed inflationary increase and reimburse the Medicaid share of the

tax. The annual impact of the provider tax proposal would have increased taxes by $.93 per non-Medicare day, providing $6.5 million in taxes.

In response to questions from Senator Meredith, Ms. Johnson stated that KAHCF's proposal to increase the provider tax was not successful because CHFS had agreed to a change in the rural and urban rate for one large corporate member. There were also concerns about the Medicaid budget. Steve Bechtel, Chief Financial Officer, Department for Medicaid Services, Cabinet for Health and Family Services, stated that one of CHFS's concerns was that those funds were received as restricted funds as cash. CHFS may receive the cash but would not have the mechanism to spend the cash. Mr. Trumbo stated that KAHCF felt there was room in the DMS budget to cover those funds. Mr. Bechtel stated that he assumed CHFS had a $122 million reduction in general funds, brought on from the 6.25 percent budget cuts that normally Medicaid is exempt from. He believes CHFS was anticipating spending some of the restricted cash or allotment on covering some of that hold.

In response to questions from Senator Carroll, Mr. Bechtel stated that the federal match would have equated to about $16 million in federal dollars. Mr. Trumbo stated that KAHCF is seeing many of the nursing facility insurers get out-of-state policies. Deductibles on policies for nursing facilities has increased, up to $100,000 in some cases. Ms. Johnson stated that facilities are seeing increases even if they do not have any claims. The Department of Insurance (DOI) told KAHCF that out-of-state insurance companies writing policies here are not necessarily regulated by DOI, policies are written thru surplus line brokers. Mr. Johnson stated that CHFS could not pay that additional amount to get the federal match for the provider tax because of the restriction of funds.

In response to questions from Representative Wuchner, Ms. Johnson stated that having at least one RN on all shifts is the goal of skilled nursing facilities. KAHCF members are constantly trying to recruit nurses but are competing against hospitals that can pay more because hospitals are reimbursed by commercial insurance.

In response to questions from Representative Gooch, Ms. Johnson stated that the KAHCF board decides its priorities and considers what is best for the entire nursing facility community. There are very few private pay facilities that do not accept Medicaid. Any nursing facility that receives Medicaid funds would benefit from the increased provider assessment.

In response to a question from Senator Meredith, Mr. Bechtel agreed that increasing provider reimbursement before the provider tax can go into effect is a cash flow problem for the state.

In response to questions from Senator Alvarado, Ms. Johnson stated that KAHCF fully supports the Medicaid waiver work requirement. KAHCF has asked CHFS to file for

a Community Networks Program (CNP) grant that will allow money that a facility has paid to the state as a result of a bad survey to go into a fund that would be used for patient care.

In response to questions from Senator Alvarado, Ms. Johnson stated that KAHCF believes that assisted living communities decide to join the association because they want education and quality initiatives and to participate in quality awards at the state and federal level.

Long-Term Care Costs and Alternatives

Jill Hunter, Commissioner, Department for Medicaid Services, Cabinet for Health and Family Services, stated that effective July 1, 2017, methodology to define urban versus rural providers was changed to Core-Based Statistical Area (CBSA) designations. The change provided $12 million additional reimbursement dollars to nursing facilities. All price-based nursing facilities will be appraised with updated depreciated replacement costs to be used in the July 1, 2019 rates. The Kentucky Level of Care System (KLOCS) will allow seamless data transmission between Benefind and Carewise. The level of care regulations should be filed by August 15, 2018 and will change the initial assessment timelines and lower the level of effort by the facility.

In response to a question from Representative Moser, Commissioner Hunter stated that DMS has a team and the Inspector General reviewing the different provider types and assessing what DMS can do to improve reimbursements.

Adjournment

There being no further business, the meeting was adjourned at 3:59 PM.