MEDICAID OVERSIGHT AND ADVISORY COMMITTEE

Minutes

November 27, 2018

Call to Order and Roll Call

The Medicaid Oversight and Advisory Committee meeting was held on Tuesday, November 27, 2018, at 10:00 AM, in Room 131 of the Capitol Annex. Senator Ralph Alvarado, Chair, called the meeting to order, and the secretary called the roll.

Present were:

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

Guests: Carol Steckel, Commissioner, Department for Medicaid Services, Cabinet for Health and Family Services; Steve Bechtel, Chief Financial Officer, Department for Medicaid Services, Cabinet for Health and Family Services; Brandon Smith, Executive Director, Office of Legislative and Regulatory Affairs, Cabinet for Health and Family Services; Maik Schutze, Executive Advisor, Office of Health Data and Analytics Cabinet for Health and Family Services; John Inman, Chief of Staff, Department for Medicaid Services, Cabinet for Health and Family Services; Russ Ranallo, Chair, Medicaid Hospital Technical Advisory Committee; Vice President, Financial Services, Owensboro Health; Nina Eisner, CEO, Ridge Behavioral Health System, Lexington, Kentucky; Pam Ryan, Utilization Review Director, University of Kentucky Healthcare; Lawrence Ford, Chair, Kentucky Association of Health Plans, Senior Director, Government Relations, Anthem Blue Cross Blue Shield; J. Leon Claywell, R. Ph.D; Beverly Loy and Kim Dykes, The Adanta Group Community Mental Health Center; and Terri Thomas, Harbor House of Louisville.

LRC Staff: DeeAnn Wenk, CSA, Dana Simmons, and Becky Lancaster.

Update on Pharmacy Benefit Manager Data Analysis

John Inman, Chief of Staff, Department for Medicaid Services (DMS), Cabinet for Health and Family Services (CHFS), stated that DMS and the Office of Data Analytics conducted data collection as required by the 2018 Senate Bill (SB) 5. The original data collection was received from all the Medicaid managed care organizations (MCOs) in August. The original data that was returned to CHFS complied with SB 5 but was incomplete and vague. CHFS determined that a useful data analysis from first round of data collection was not possible. CHFS and DMS developed a new data collection instrument. The new data instrument was forwarded to the MCOs in August for submission

in November. Internal and external analyses are being conducted and results are expected by early January 2019.

Maik Schutze, Executive Advisor, Office of Health Data and Analytics, Cabinet for Health and Family Services, stated that the Pharmacy Services Administration Organization (PSAO) are administrative service organizations that allow independent pharmacies to come together and purchase in a group setting. There are three types of pharmacies: retail, independent, and common ownership. Drugs are categorized into three groups: brand, generic, and specialty drugs. Brandon Smith, Executive Director, Office of Legislative and Regulatory Affairs, Cabinet for Health and Family Services, stated that other states such as Ohio, Arkansas, and West Virginia have issued reports within the last year that have excluded data or were unable to analyze such data. CHFS hopes to provide a more detail report with numbers on the incoming data and the trends that follow.

In response to questions and comments from Senator Meredith, Mr. Smith stated that CHFS is not contracted directly with the PBMs and communication regarding the PBMs goes through the MCOs that are contracted to CHFS. MCOs are willing to comply and work with subcontractors. Many conversations and much research was focused on the how to combine information from different MCOs that have various PBMs and diverse definitions of similar terms in the data. Mr. Inman stated that CVS Caremark does work with the majority of the MCOs. Express Scripts is another large PBM. Mr. Smith stated that Kentucky also uses a third PBM for the fee-for-service population. Mr. Schutze stated that CHFS did have some concerns about the data quality because DMS was looking at the data with a limited amount of information available in the initial data template. CHFS approached the MCOs because the data did not seem realistic but are now confident that data will be corrected with the next submission. CHFS built statistical tools that will help give a better sense of how reliable the data is from the MCOs and PBMs.

Mr. Inman stated that he learned there is a negotiated rate between the MCOs and the PBMs. The PBMs can capitalize on pricing and rebates and that is how they can expand or narrow their profit margins. Mr. Smith stated that because MCOs and PBMs operate as competitors and have separate contracts with different operators at the MCO level and provider level, there is more disparity with the definitions of the data than originally expected. Mr. Schultze stated that the challenge is how to demonstrate or observe the differences in the data that is provided. Mr. Smith stated that CHFS has also gained knowledge from independent pharmacists on understanding definitions and what they mean to specific partners and in different parts of the state. He stated that there are times when providers and DMS have adversarial relationships on particular issues but the relationships overall have been fairly positive.

In response to questions and comments from Senator Carroll, Mr. Inman stated that in regards to indirect fees, it will be hard for the data collection tool to determine how

complete the data is because there are no previous benchmarks or other data to put the new information into context. There are enforcement mechanisms for contract compliance within the contracts with the MCOs. The independent consultant should have a preliminary analysis on the new template that CHFS provided in early December.

In response to questions and comments from Representative Gibbons-Prunty, Mr. Smith stated that independent pharmacists are not forced or legally required to enter a PSAO, but many often find a PSAO to be an economic reality that is a good idea. The independent pharmacies face tremendous challenges across the state particularly in rural communities.

In response to questions and comments from Senator Alvarado, Mr. Inman stated that the data CHFS has received does not show if PBMs are paying themselves more than they are paying independent pharmacies for the same prescriptions. Mr. Smith stated that the incoming data will be able to give CHFS an understanding on the types of pharmacies and the payment differentials. He stated that part of the statutory requirements and data collection does include an analysis of individual PBMs that have fiduciary interest or common ownership with providers at the pharmacy level. Mr. Inman stated that CHFS has a meeting scheduled with the West Virginia pharmacy team to discuss how they completed data analysis regarding PBMs. The MCOs and PBMs relationship with CHFS has been easy to manage with points of conflict but continues to improve. CHFS has held MCOs accountable on certain issues, discussed policy and operation changes, but that is normal with any business partner.

In response to questions and comments from Senator Meredith, Mr. Smith stated that CHFS and DMS have the ability to require data from the PBMs to be submitted but that functions through the contractual relationship with the MCOs. The MCO claim data is valuable because the MCOs process claims data for many individuals and serves as another check point on whether or not CHFS trusts the incoming data. The data is confusing because it goes through many individual providers and different MCOs' formularies using different methodology. There is a sense of urgency within CHFS leadership, DMS frontline and program staff because the data involves a lot of money, providers, and members.

In response to questions and comments from Representative Jenkins, Mr. Schultze stated that the new data submissions should include detail about retail specialty mail order prescription drugs.

Approval of Minutes

A motion to approve the minutes of the August 15, 2018 meeting was made by Senator Meredith, seconded by Representative Jenkins, and approved by voice vote.

Medicaid Managed Care Organizations Report: Overview

Steve Bechtel, Chief Financial Officer, Department for Medicaid Services, Cabinet for Health and Family Services, stated that according to the Milliman Report, Kentucky had the highest estimated profit margins in the nation in calendar year (CY)2015. Kentucky was reported as having an estimated profit margin of 11.3 percent, compared to the national average of 2.6 percent. CHFS brought in an independent contractor to do a thorough analysis of the rates and rate setting methodology. The analysis resulted in CHFS renegotiating the rates with the MCOs which created savings that has decreased Kentucky's MCOs profit margins significantly. The CY2017 Milliman report shows an estimated profit margin of 3.1 percent, compared to the national average of 0.9 percent. The nation average decrease can be explained based on the number of plans across the nation that reported a loss, driving the overall average down.

The MCOs' rates assume a one percent margin but MCOs can obtain higher profitability through administrative cost efficiencies. In the state fiscal year (SFY)2017, DMS implemented a minimum medical loss ratio (MLR) requirement of 90 percent. Actuaries and financial analysts use the MLR as a measure of premium adequacy. In SFY2017 based on data obtained by DMS actuaries, the MCOs had a composite MLR of 93.4 percent, all MCOs were above the required 90 percent. The formula used by DMS is consistent with the Centers for Medicare and Medicaid Services (CMS) methodology, which is different from the Milliman MLR formula.

Stephanie Bates, Deputy Commissioner, Department for Medicaid Services, Cabinet for Health and Family Services, stated that DMS is delaying the release of the request for proposal (RFP) to allow more time for development. Commissioner Steckel stated that DMS wanted to have time to strengthen the contract. DMS has good partnerships with the MCOs but DMS will verify the information received and will confirm that penalties are imposed if the MCOs are not following the contracts. The Advisory Council for Medical Assistance (MAC) meets once every two months and gives all provider groups an opportunity to raise issues.

In response to questions and comments from Senator Carroll, Mr. Bechtel stated that the Kentucky Hospital Association (KHA) has a report with an estimate of the costs to the state during the MCOs' two years of high profit margins. In January 2018, DMS under estimated the number of people that would apply and receive Medicaid coverage during the expansion. DMS will be researching how to streamline the credentialing verification process without stifling the MCOs creativities and innovations. For the new RFP, DMS wants to improve members' health status by measuring quality by outcomes. DMS will research program integrity. Ms. Bates stated there will be outcome based language and value based payments that could filter to the providers. Commissioner Steckel stated that ongoing problems with invalid codes should not be happening. She stated that the best way to resolve claim issues is to send DMS staff member specific claim information.

In response to a question from Representative Jenkins, Mr. Bechtel stated he would send a copy of his presentation to the Medicaid Oversight and Advisory Committee staff for distribution.

In response to questions and comments from Senator Meredith, Commissioner Steckel stated that reducing the number of MCOs in Kentucky to three instead of two is preferable to create competition between the MCOs. DMS is not required to have five MCOs and is considering reducing the number of MCOs in the new RFP.

In response to questions and comments from Senator Alvarado, Commissioner Steckel stated that she is concerned with provider led entities but is open to consider other types of managed care entities other than the formal MCOs that are in place. The Department of Insurance (DOI) would have the current uninsured rate for Kentucky. In the 1915(C) Kentucky Health waiver redesign, DMS is reviewing how to look at the population in the waiver programs. Waiver program members have a high acuity level, different providers, and various community service needs. DMS wants to be able to establish the definitions of terms across the waivers to create continuity throughout the different waiver programs. The process of reviewing a coordinated care system is a slow process that should include discussions with providers and recipients.

Hospitals and Medicaid Managed Care Organizations

Russ Ranallo, Chair, Medicaid Hospital Technical Advisory Committee, Vice President, Financial Services, Owensboro Health, stated that the annual report produced by KHA on the MCOs' performances covers the MLR of the MCOs, quality ratings, prior authorization denials, complaints, and prompt payments. KHA, MCOs, and DMS staff meet once a month discuss and track issues raised by the hospitals. The overall average of the number of days that issues are outstanding is the lowest since the beginning of 2018. Typically, hospitals bring issues to the meeting however, the MCOs can also recognize an issue and put it on the list to be tracked. The trend in the rate of issue days per 10,000 members shows consistent performance by Anthem and good improvement by other MCOs with exception of Humana Care Source. At Owensboro Health, Medicaid is about 20 percent of the business but the administrative time spent on Medicaid takes up 75 percent of the time.

Prior authorization denial issues have been discussed in the Technical Advisory Committees (TAC) meetings. Mr. Ranallo found that one MCO was responsible for two-thirds of the prior authorization denials in surgery. He asked for prior authorization lists from all the MCOs and each list was very different. One MCO had 14,000 items on its prior authorization list. He stated that MCOs are approving procedures but denying supply charges for supplies used during a procedure. There are also coding issues among MCOs

even when using the American Hospital Association coding guidelines. The appeal of a code is being reviewed by a qualified physician but not a coder creating more denials.

Pam Ryan, Utilization Review Director, University of Kentucky Healthcare, stated that in 2017, University of Kentucky Healthcare had 11 completed state fair hearings and 2 in 2018. They currently have 12 hearings pending from 2017 and 4 from 2018 for lack of receiving a hearing date. University of Kentucky Healthcare is losing money in the state fair hearings due to the costs for lawyers, administration, and physician advisors. They continue to appeal in hopes of changing the behaviors of the MCOs. Hearing officers can only process Interqual criteria qualified cases. It can take approximately 9 to 12 months or longer to get an admission to state fair hearing. The reviewers do not consistently review the entire chart or use Interqual criteria properly to determine inpatient status. The hearing officers have no clinical or Interqual experience. For each hearing, the hearing officer must be taught how to use Interqual criteria. The hearings typically last three to four hours.

Nina Eisner, CEO, Ridge Behavioral Health System, Lexington, Kentucky, stated that medical necessity criteria for behavioral health providers is even more complex because there are five different sets of criteria that must be followed. The denial is appealed and is usually overturned at the IPRO level. Now the MCOs are taking behavioral health providers to state fair hearings to challenge that IPRO decision. For a behavioral health provider to hire an attorney to go to a state fair hearing is most likely more costly than the total cost of the denied days. Behavioral health providers feel the need to fight for medically necessary care to give the best outcome to the patient.

In response to questions and comments from Senator Alvarado, Ms. Eisner stated that state fair hearings have advanced more quickly through the system for her than other providers. Ms. Ryan stated that the biggest delay in the appeal process is the large volume of denials and their limited amount of staff that can work the denials. She stated that getting a hearing date is also a challenge. Providers are not allowed to lump similar case denials together for one larger appeal but each denial must be appealed separately.

Adjournment

There being no further business, the meeting was adjourned at 12:27 PM.