INTERIM JOINT COMMITTEE ON HEALTH AND WELFARE AND FAMILY SERVICES

Minutes of the First Meeting of the 2019 Session Break

January 23, 2019

Call to Order and Roll Call

The first meeting of the Interim Joint Committee on Health and Welfare and Family Services during the Session Break was held on Wednesday, January 23, 2019, at 10:00 a.m., in Room 129 of the Capitol Annex. Senator Ralph Alvarado, Co-Chair, called the meeting to order at 10:05 a.m., and the secretary called the roll.

Present were:

Members: Senator Ralph Alvarado, Co-Chair; Representative Kimberly Poore Moser, Co-Chair; Senators Julie Raque Adams, Tom Buford, Danny Carroll, Julian M. Carroll, David P. Givens, Morgan McGarvey, Stephen Meredith, and Max Wise; Representatives Danny Bentley, Tina Bojanowski, Adam Bowling, George Brown Jr, Tom Burch, Daniel Elliott, Deanna Frazier, Robert Goforth, Mary Lou Marzian, Melinda Gibbons Prunty, Steve Sheldon, Nancy Tate, and Russell Webber.

Guest Legislators: Senator Jimmy Higdon; and Representatives Jim Gooch and Joni Jenkins.

Guests: Lawrence Ford, Chairman, and Stephanie Stumbo, Acting Executive Director, Kentucky Association of Health Plans; Jonathan Copley, Chief Executive Officer, Vaughn Payne, MD, MBA, CPE, FACC, FAHA, Chief Medical Officer, Russell Harper, Senior Director, State Government Affairs, and Paige Mankovich, Director, Strategic Planning, Aetna; Leon Lamoreaux, Kentucky Medicaid President, Kentucky, Tennessee, and West Virginia Market President, and Victoria Meska, MSN, RN-BC, CCM, Director, Health Care Management Services/Case Management, Anthem Blue Cross Blue Shield Medicaid; Jeb Duke, Executive Director Humana CareSource, Lisa Galloway, MD, MRO, FACOEM, Kentucky Medical Director Humana CareSource, and Travis H. Garrison, Regional Field Director, Public Affairs, Humana; Ben Orris, Chief Operating Officer, Tim Houchin, MD, MHCDS, Behavioral Health Medical Director, and Michael Ridenour, Vice President of Government Affairs, WellCare; Mark Carter, Chief Executive Officer, and Carl Felix, Vice President and Chief Operations Officer, Passport; David Trimble, General Counsel, Department of Professional Licensing, Public Protection Cabinet; Phill Gunning, NAMI Lexington; Chris Heldman and Jeff Nowlin, Molina Healthcare; Troy Walker and Joe Prewitt, Kentucky Ambulance Providers Association; Mike Poynter and Phil Dietz, Kentucky Board of Emergency Services; and

Jeremy Koonce, Louisville Metro Emergency Medical Services/Kentucky Ambulance Providers Association.

LRC Staff: DeeAnn Wenk, Ben Payne, Chris Joffrion, Dana Simmons, and Gina Rigsby.

Consideration of Referred Administrative Regulations

The following referred administrative regulations were placed on the agenda for consideration**: 201 KAR 021:015** – establishes the minimum standards of professional and ethical conduct and practice that a licensee shall maintain; **201 KAR 021:045** - implements KRS 312.021 (specialties of chiropractic for which certification may be granted); **201 KAR 026:130** – established to protect and safeguard the health and safety of the citizens of Kentucky and to provide procedures for filing, evaluating, and disposing of administrative complaints asserted against credential holders or applicants to licenses (Board of Examiners of Psychology); **201 KAR 026:140** – establishes procedures which supplement the provisions of KRS Chapter 13B (Kentucky Board of Examiners of Psychology procedures for disciplinary hearings); **201 KAR 026:171** – establishes the requirements for supervision of a certified psychologist, licensed psychological associate, candidate for licensure, or a credential holder sanctioned by the board; **201 KAR 026:175** – establishes the continuing education requirements for renewal of a license (Kentucky Board of Examiners of Psychology); **201 KAR 026:200** – establishes education requirements for licensure by the board (Kentucky Board of Examiners of Psychology); **201 KAR 026:211** – repeals 201 KAR 26:210 which establishes educational requirements for licensure as a psychological associate because these provisions have been consolidated into 20 KAR 26:200; **201 KAR 026:280** – establishes the requirements for applicants for licensure and the conditions for a temporary license as a psychological associate; **902 KAR 008:165** – establishes minimum accounting and auditing requirements for Kentucky's local public health departments; **902 KAR 008:170** – establishes minimum fiscal and financial management requirements for Kentucky's county and district local health departments and for all other classes of local health departments, except if a specific Kentucky revised statute requires a more stringent minimum requirements; **922 KAR 001:060** – establishes guidelines for the implementation of the federal Title IV-E adoption assistance program for children who may otherwise grow up in foster care; and **922 KAR 001:360 & E** – establishes: (a) five (5) levels of care based upon the needs of a child for whom the cabinet has legal responsibility; (b) a payment rate for each level of child-caring facilities and child-placing agencies; (c) gatekeeper responsibilities; (d) provider requirements; (e) procedures for classification at the appropriate level of care; and (f) procedures for determination of components of the model program cost. David Trimble, General Counsel, Kentucky Department of Professional Licensing, Public Protection Cabinet, was present to answer questions on 201 KAR Chapter 26 administrative regulations. A

motion to accept the referred administrative regulations was made by Representative Webber, seconded by Senator Meredith, and approved by voice vote.

Medicaid Managed Care Organizations

A. The Kentucky Association of Health Plans

Lawrence Ford, Chairman, and Stephanie Stumbo, Acting Executive Director, stated that the goal of the MCOs is to assure Kentucky's most vulnerable citizens are provided access to the healthcare that they need in the right setting at the right time. The MCOs are charged with being good stewards of Medicaid dollars, improving access to care for the most vulnerable citizens, and providing quality medical coverage to beneficiaries within the rates set by the Commonwealth. Managed care is a health organization system organized to manage cost and utilization while attempting to improve quality of care for its beneficiaries. Currently, there are 40 states that contract with Medicaid Managed Care Organizations (MCOs) or Prepaid Inpatient Health Plans (PIHPs). MCOs play a key role in the reduction of Medicaid program costs, better utilization of health services, yield improvement in health plan performances, healthcare quality, and coordination and integration of care through initiatives that focus on the overall health of the patients.

One component of the 2010 Affordable Care Act that began in 2011 was that health plans were held accountable to an 80 percent medical loss ratio (MLR) in the commercial insurance market for both the individual and small group markets. In the large group market, private health plans were held to an 85 percent standard. In 2016, the Centers for Medicare and Medicaid Services (CMS) issued a final regulation that addressed and significantly strengthened the rules and regulations around Medicaid managed care. The final federal rule published in April 2016 established a minimum MLR requirement within Medicaid of 85 percent for MCOs. In Kentucky, the rate year is the state fiscal year. There is no requirement in the final rule that the MCOs who fail to reach the required MLR return any of the money, but states have the discretion make this a requirement. In Kentucky, the MLR is 90 percent medical claims and quality improvement activities, 9 percent non-medical expenses, and 1 percent profit margin as defined in the rate setting process. On November 27, 2018, the Department for Medicaid Services (DMS) reported to the Medicaid Oversight and Advisory Committee that the SFY 2017 medical loss ratio (MLR) was 92.7 percent for Aetna Better Health of Kentucky, 92.7 percent for Anthem, 95.7 percent for Humana/Humana CareSource, 95.1 percent for Passport, and 91.9 percent for WellCare. A requirement of the contract between DMS and the MCOs is MCOs have to return 75 percent of any margin or profit earned below 90 percent down to 86 percent and 100 percent of any margin earned beneath 86 percent.

B. Aetna

Jonathan Copley, Chief Executive Officer, Vaughn Payne, MD, MBA, CPE, FACC, FAHA, Chief Medical Officer, and Paige Mankovich, Director, Strategic Planning, stated that Aetna administers Medicaid programs in 16 states for 2.2 million members with 236,993 of this total being served in Kentucky. Aetna is committed to building a healthier Kentucky one person, one community at a time. In 2018, the National Committee for Quality Assurance (NCQA) rated Aetna Better Health of Kentucky with a commendable accreditation, one of the highest ratings among MCOs that excelled in consumer satisfaction. From 2017 to 2019, the Kentucky Hospital Association activity log showed that Aetna decreased member reported issues by 90 percent. Beginning January 1, 2019, Aetna Better Health of Kentucky, the Kentucky Pharmacy Care Network, and the Community Pharmacy Enhanced Services Network (CPESN) began a 12-month pilot program. CPESN will have care plans to assess and identify social determinants of health for members, allowing Aetna's care managers to assist with transportation, food, and safety concerns. Aetna Better Health of Kentucky participates in workgroups of the Barren River Initiative to Get health Together (B.R.I.G.H.T.) Coalition to deal with substance abuse issues in the district and are assisting in completing the 2019-2021 Community Health Improvement Plan (CHIP). In partnership with the Health Access Nurturing Development Services (HANDS) Program, Aetna offered member appreciation baby showers during open enrollment in Montgomery, Jefferson, Barren, Pulaski, Russell, Franklin, Woodford, Fayette, McCreary, and Mercer counties. Aetna is working with the Kentucky Hospital Association to complete a delegated credentialing agreement in conjunction with 2018 House Bill 69 relating to service delivery improvements in managed care networks.

Aetna Better Health of Kentucky partnered with ten University of Kentucky Medicaid Assisted Therapy prescribers that have been deemed preferred providers. As a preferred provider, Aetna does not require prior authorization for Buprenorphine (suboxone) prescriptions giving discharged patients immediate access to their prescription. Aetna is partner with KentuckyOne to pilot Care Unify software that targets care gap analysis. Aetna is in the process of developing a collaborative agreement with the Children's Alliance to provide a value based savings arrangement children and adolescents with behavioral health needs. Aetna Better Health of Kentucky is teaming up with community partners to enhance case management support for its members. It is also working with Pursuant Health to add kiosks in retail locations in all regions where members can perform Healthcare Effectiveness Data and Information Set (HEDIS) incentives tasks, participate in interactive materials such as surveys, and receive literature.

Aetna worked with the Kentucky County Detention Center for members to start a 90-day Jail Substance Abuse Program. After completion of the program, members receive treatment, housing, and job training for an additional six months. Aetna Better Health of Kentucky is the largest provider of managed care coverage for foster children

in the state serving 50 percent of eligible children. In addition to primary care and specialty medical providers, Aetna's program integrates the Department of Juvenile Justice (DJJ), the Commission for Children, the Department for Community Based Services (DCBS), and other key agencies into the individualized care plans for each of the children. Aetna is involved in the Kentucky Quit Incentives for Program Smokers (QuIPS) pilot incentive-based cessation initiative for Kentucky's Medicaid members. Aetna provides first responders in Northern Kentucky and Appalachia regions with 720 doses of Narcan. Aetna renovated space in the Jefferson County Courthouse for an Exploited Children's Help Organization (ECHO) and Aetna Better Health of Kentucky Safe Zone where children can read and play in a safe environment while their parents are in Family Court. Aetna case managers complete face to face visits by meeting homeless members in their own environment. Case managers have visited over 45 agencies in Elizabethtown, Hazard, Lexington, Louisville, Owensboro, Pikeville, and Richmond. Community development offers ongoing evidence-based and internally developed education courses throughout the community which improves the quality and promotes healthy living for all members. Russell Harper, Senior Director, State Government Affairs, was available to answer questions from members.

C. Anthem Blue Cross Blue Shield Medicaid

Leon Lamoreaux, Kentucky Medicaid President, Kentucky, Tennessee, and West Virginia Market President, and Victoria Meska, MSN, RN-BC, CCM, Director, Health Care Management Services/Case Management, stated that in January 2014, Anthem began serving individuals in 105 counties that offered Medicaid expansion services, and in July 2014, Temporary Assistance for Needy Families (TANF) recipients were added. Anthem currently serves 130,000 Medicaid recipients throughout all 120 counties. In 2017, Anthem received NCQA accreditation, and in 2019, implemented member co-payments. Approximately 52 percent of Anthem's Medicaid recipients are part of the Medicaid expansion population. Anthem's philosophy is one of collaboration serving everyone with a focus on individuals with the greatest need coordinating health for the whole person including not only care coordination but also food security, transportation, stable housing, education, and gainful employment. Needed services are facilitated through evidence-based review process and sophisticated predictive modeling to eliminate unnecessary services, to improve quality, enhance the member experience, and reduce costs. Anthem is committed to the Commonwealth and its most vulnerable citizens.

D. Humana/Humana CareSource

Jeb Duke, Executive Director Humana CareSource, and Lisa Galloway, MD, MRO, FACOEM, Kentucky Medical Director Humana CareSource, stated that as of September 2018, Humana serves 918,100 plan members throughout all of its insurance plans. Members have access to many providers including specialists without the

requirement of referral. Humana's Bold Goal is a business and health strategy to help improve the health of the communities it serves by 20 percent by 2020 by making it easier for people to achieve their best health. Progress is tracked using the CDC tool, Healthy Days, which measures self-reported mental and physical unhealthy days of an individual over a 30-day period. The Louisville Health Advisory Board's mission is to improve the physical, mental, and social well-being of Louisville and the surrounding neighborhoods, with the goal of increasing the number of Healthy Days. The focus is on behavioral health, communications, community care coordination, cultural and social impact, diabetes, and respiratory health.

In 2017, Humana launched a claims adjudication process to further enhance capabilities and promote real-time adjudication. In 2017, Humana Program maintained a 98.9 percent first pass for clean claims, and a 4 percent pending rate for manual intervention. In 2018, Medicaid claims had an automatically adjudicated rate of 75 percent, and over 99 percent of clean claims were paid within 20 days. Case management and care coordination consist of multidisciplinary teams that are located throughout Kentucky that include registered nurse care managers, social worker care coordinators, and community health workers with support and collaboration from medical directors and a pharmacy director. Humana CareSource has a mission-driven approach to improve the health and well-being of its members. All children in foster care engage in care coordination and case management. Regular reviews of all foster care cases are conducted to identify upcoming and outstanding care gaps, such as preventive services and immunization. Humana CareSource actively works with DCBS to eliminate barriers around foster parent communication to support member placement needs and clinical services. Provider engagement representatives deliver individual or group reports to the provider during an onsite visit to aid in identifying and improving clinical outcomes. Quality Specialists are assigned to provider engagement regions to assist with any clinical questions or concerns. A Proactive Full-Service Model is offered to providers. Provider engagement representatives are assigned to a provider who visit provide face to face visits annually based upon the number of members assigned to a provider. Travis H. Garrison, Regional Field Director, Public Affairs, Humana, was present to answer questions from members.

E. WellCare

Ben Orris, Chief Operating Officer, Tim Houchin, MD, MHCDS, Behavioral Health Medical Director, and forensic psychologist, and Michael Ridenour, Vice President of Government Affairs, stated that WellCare started in Kentucky in 2011 and has six offices statewide, and has 484,000 members and 34,000 providers. Humana received an overall NCQA score of 3.5 out of 5, the highest score achieved in the state in 2018, and earned more 4 ratings and above than any other Kentucky plan for consumer satisfaction, prevention, and treatment measures. Based upon an external provider satisfaction survey, WellCare had the highest provider satisfaction in the state and was

named to the Top 10 best places to work in Kentucky. WellCare connects its members with resources that assist them with housing, transportation, and child care, paving a path toward better health and independence. Additionally, WellCare forms partnerships designed to strengthen the network of resources. Approximately 9,958 community members in Kentucky received 54,892 referrals to social resources such as transportation, food utility assistance, and homeless services. Removing social barriers led to an aggregated saving in inpatient spending, emergency room use, and emergency department spending. The healthcare savings from removing social barriers is reinvested back into the community through over 800 investments designed to increase data sharing capabilities or sustain critical social services.

In 2018, WellCare invested in 91 community health initiatives in Kentucky with particular focus on healthy food access, access to healthcare, and healthcare for the homeless. These initiatives provided more than 240,216 social services to community members. Behaviors and environment determine 70 percent of health outcomes and 30 percent is due to genetics and medical care. Delivering medical, behavioral, and social supports help member live better, healthier lives. WellCare's vision is to be the child welfare managed care leader in collaboration with its members, providers, and state partners. It has a team of 8 specialized clinicians and staff that serve 7,810 foster and adopted members. Specialized programs are acute behavioral health case management, autism program, and JOOL health coach phone application for transition-age youth that can help achieve lasting, positive change. WellCare Works is a program connecting Medicaid members to tools and services for work and education success that include online job-seeking resources, community connections help line, and educational services.

F. Passport

Mark Carter, Chief Executive Officer, and Carl Felix, Vice President and Chief Operations Officer, stated that Passport began in 1990 as an 1115 waiver as a partnership between DMS, the provider community, and Passport. Passport is provider-sponsored, non-profit, tax-exempt, and mission-driven organization organized under the IRS provisions as a public charity entity. Passport uses a medical spending ratio model not a medical loss ratio model like the other five MCOs. Passport serves individuals in Region 3 which has the highest Medicaid MCO population of 65 percent market share compared to other regions that have 14 percent or less market share. Passport's statewide membership is 25 percent. Managed care has been a tremendous value for Kentucky, significantly driving down the cost of Medicaid compared to the old fee-for-service model. Passport has been at the forefront of these cost-savings for more than 20 years. Passport includes the University of Louisville Physicians, Louisville/Jefferson County Primary Care Association, Norton Healthcare, Inc., Jewish Heritage Fund for Excellence, and University Medical Center, Inc. Passport currently has over 144 clinicians, PCPs, specialists, pharmacists, representatives from hospitals, and advocates serving on its committees.

Passport spends 90 cents for medical care, 9.5 cents on administrative costs, and .5 cents profit margin for the past 20 years. The five for-profit MCOs spend 86 cents for medical care and 14 cents for administrative costs and profit. In 2017, for-profit MCOs paid nearly $1 billion to shareholders. Passport started an Intensive Care Management Foster Care Pilot Program focused on a team decision making structure that promote youth and family choice. The program included 60 high risk children between 4 and 17.5 years of age. Participants increased their placement with natural or adoptive families compared to pre-intervention placements and decreased institutional settings for services. Total managed care costs for the youth in the nine months post-intervention were greatly reduced compared to pre-intervention. Passport provided a $25,000 grant to the Kentucky State Police (KSP) Foundation to purchase fentanyl response kits that will help KSP troopers avoid contact with dangerous drugs. Passport community engagement representatives spent 250 hours in a resource center hosted by the Department of Local Government in Estill, Owsley, Breathitt, and Lee Counties over an eight-day period. Passport has a value-based program with seven large provider groups that make up approximately 60 percent of primary care physicians in the network. The state was reorganized into two rating regions, Region A which includes Passport, and Region B that includes the rest of the state. Region A was the only region that received a decrease in rates while Region B received a 2.2 increase. Passport has a 65 percent market share, so the decrease in rates affects Passport disproportionately. If Passport's losses continue at the current level, the Department of Insurance (DOI) which is charged with the responsibility of making sure that insurance companies maintain an appropriate level of solvency could take action against Passport as early as March 2019. On January 9, 2019, Passport used the dispute resolution provisions in its contract and filed a formal appeal to the Secretary of the Cabinet for Health and Family Services that will also be reviewed by the Secretary of the Finance and Administration Cabinet. Passport has a mission to improve the health and quality of life of its members. Its values are integrity, collaboration, community, and stewardship.

In response to questions by Senator Meredith, Mr. Ford stated that the MCOs have to work within the rate approved by DMS and CMS. If provider reimbursement is increased, the rate must also increase. Anthem's network consists of largest amount of hospitals and physicians.

In response to questions by Senator Danny Carroll, Mr. Ford stated that in 2018, Anthem paid 90.9 percent on a run rate basis was used for benefit expenses that pay claims from providers. Mr. Ford said that he would provide information on behalf of Anthem on the percent of benefit expenses that go towards care and not programs. No MCO has a systematic approach to delaying or denying claims on a regular basis to manage cash flow. Mr. Orris stated that there is no advantage to an MCO to exceed the

statutorily required 30-day prompt payment of claims because interest would have to be paid on the overdue amount.

In response to questions by Senator Carroll, Mr. Felix stated that because of multiple complaints from multiple providers, Passport is actively working to remove the Multiple Procedure Payment Reduction (MPPR) for Selected Therapy Services for adolescent children by March 2019. Senator Carroll stated Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is the child health component of Medicaid. Federal statutes and regulations state that children under age 21 who are enrolled in Medicaid are entitled to EPSDT benefits and that states must cover a broad array of preventive and treatment services.

In response to questions by Senator Wise, Mr. Ford stated that Anthem contracts with Express Scripts not CVS/CVS Caremark as its pharmacy benefit manager (PBM). Anthem plans to form its own PBM in the near future. Mr. Orris stated he was unaware of a 1.6 percent reimbursement reduction for pharmacies. If it did occur, an MCO would be required by 2016 Senate Bill 18 to send pharmacy providers a notice of the change to the contract in an orange envelope and sent by certified mail. Any provider communication has to go through WellCare's regulators for approval. Senator Wise stated that on January 15, 2019, CVS announced that Walmart pharmacies are leaving its network because of a dispute over pricing. He stated that DMS needs to be in charge of the reimbursement rates for pharmacy services.

Representative Burch stated that Kentucky needs to make sure the poor citizens in need to be able to access services.

In response to questions by Representative Goforth, Mr. Ford stated that the 90 percent medical claims and quality improvement activities include medical and pharmacy claim payments to providers. Profits are kept in check through targeted requirements. PBM profits are separate from MCO profits. The DOI regulates PBMs. The data received by the MCOs was not the data that was needed, and MCOs are currently in the process of providing more detailed information. MCOs operate with a targeted margin of 1 percent to maintain the stability and financial viability of the company. In 2018, the General Assembly passed legislation that imposed a $2 reimbursement increase for the dispensing fee of each script. DMS reviews a contract once an MCO subcontracts with a PBM of its choice.

In response to questions by Senator Buford, Mr. Felix stated that Passport received a PowerPoint presentation from the actuarial firm that showed the distribution of rate changes by Region. There was a .8 percent overall statewide average increase, but when the rates were examined closer, it was a 2.2 percent increase in Region B and a 4.1 decrease in Region A where Passport is located. There were no preliminary review of the

rate changes by any of the MCOs prior to them being published. Once the rates are published, it gets difficult to get them changed. One explanation given by the cabinet was that it is an independent actuarial process that the cabinet has no control of the outcome. Passport's call center in located in Louisville and Prestonsburg.

In response to questions by Representative Marzian, Mr. Carter stated that Passport has lost $60 million due to the 4.1 percent rate reimbursement change. Mr. Ford stated that he could not address if providers received a raise after the MCOs were given a 2.2 percent rate increase. Mr. Felix stated that Passport wants to have a meeting between its actuaries, the cabinet's actuaries and work to together to find a reasonable solution. There is a process followed when data is submitted by the MCOs. Rates should be shown to MCOs before the final decision is made in order to deal with issues that may arise from the changes. Mr. Ford stated that in 2018, Anthem's Medicaid run rate margin was $15.5 million.

In response to a questions by Senator Alvarado, Mr. Copely stated that Aetna's call center is in Louisville. Aetna has national actuaries that work on rate setting processes in 16 states and watch rate settings in the other states. The process in Kentucky is not dissimilar or inconsistent with other states. Mr. Duke stated that Humana CareSource's experience in Kentucky is consistent with other states. The implication that a 1 percent profitability margin is guaranteed for every MCO in Kentucky is not true. MCOs go through the rate setting process and align critical programs and trend development in order to have a program that meets the state requirements. Mr. Lamoreaux stated that the vast majority of the process is very similar based on encountered data submission to the state in order to create a fair and equitable distribution based on risk score and risk score adjustments.

In response to questions by Senator McGarvey, Mr. Copely stated that Aetna has made allot of improvements since the MCO started serving Kentucky Medicaid recipients. Aetna has worked diligently to fix provider issues, and will work with legislators to help with issues raised by their constituents.

In response to questions by Senator McGarvey, Mr. Duke stated that sometimes claims are rejected, not necessarily denied, in order to fix a claim. Kentucky uses encounters to set rates, so MCOs need to ensure that every claim from providers is accepted. Sometimes there is a struggle of taking a claim, figuring out if all the information is needed to accept the claim to be able to pay the provider then to submit the encounter to the state. Providers need to be educated more on how to submit clean claims. Senator McGarvey asked the MCOs to provide the committee the percentage of claims that are initially rejected or denied but eventually paid.

In response to questions by Senator McGarvey, Mr. Carter stated that Passport has 200,000 Medicaid recipients plus hundreds of employees whose lives will be disrupted or effected if Passport is not able to remain solvent because of the reduction in rates. The Sexual Assault Nurse Examiner program at the University of Louisville is one of many programs at risk, because Passport is the only MCO that funds this program. The current Governor and his administration has been very supportive of the building being built in West Louisville where Passport will be one of its occupants. The primary tenant would be Evolent Health. Passport is using two new market tax credits and a Tax Increment Financing (TIF) established by Louisville Metro. If Passport does move to the new building, its occupancy costs would increase approximately $2 million a year on a $2 billion budget. Almost $112 million a year of taxpayer money is spent in West Louisville zip codes associated with poor health in excess of what is spent on average in the rest of the state. The new building is completely independent of Medicaid, but it is an economic development opportunity that can transform the community and help reduce healthcare costs over time.

In response to questions by Representative Bentley, Mr. Carter from Passport, Mr. Duke from Humana CareSource, and Mr. Payne from Aetna stated that they were unaware of the 55 cents to 45 cents decrease in the dispensing fee. The price determined between a PBM and independent pharmacies is negotiated through a prescription services administrative organization (PSAO). Pharmacy is the same as other benefit expenses when determining the MLR. The data required by 2018 Senate Bill 5 has been supplied to DMS by the MCOs.

Senator Alvarado stated that he had meet with cabinet representatives to discuss PBM data, and the cabinet needs more data from the MCOs before a report would be published. The preliminary data show that there needs to be some changes made in the contracts with the MCOs.

In response to questions by Representative Sheldon, Mr. Ford stated that Anthem has announced its intention to create its own PBM, and there is litigation pending with Express Scripts. Mr. Houchin from WellCare stated that he would need to get back with the committee on the specific RFP equation that goes into the selection of a PBM. It is a national process that is used for Medicaid and Medicare members. Mr. Vaughn from Aetna stated that they too have a national process that results in serving its commercial, Medicaid, and Medicare members. Mr. Duke from Humana CareSource stated that it looks for value and quality when choosing a PBM. CVS Caremark is not used for all products and does not mean the Humana will continue to use CVS Caremark indefinitely. Mr. Houchin from WellCare stated that WellCare's corporate finance team handles the RFP process to select a PBM. Mr. Payne stated that the RFP process is handled at the national level, but stated that he would get the information for the committee. Mr.

Houchin stated that there is concern that CVS Caremark is owned by an insurance company.

In response to questions by Senator Higdon, Mr. Ford stated that MCOs went statewide in November 2011. Senator Higdon stated that another conversation that needs to take place concerning whether Kentucky's citizens are healthier since the implementation of the MCOs. He questioned whether pharmacy benefits should be carved out of the money given to the MCOs. Pharmacies need to be protected because they play a vital role in the healthcare delivery system in Kentucky.

Senator Danny Carroll requested that each MCO provide the committee information on how much of the medical expenses goes to providers and how much goes to programs.

In response to questions by Senator Meredith, Mr. Carter stated that Passport is not on the verge of bankruptcy, but if the run rate of losses continues, there is a possibly that Passport could be deemed insolvent by DOI by mid-2019. Passport and DMS need to work collaboratively to find a solution. Teaching hospitals have access to special payment provisions that are passed through from DMS through the MCOs. Passport's policies for provider payments are equitable across its system. All of Passport's providers do not feel like they are adequately paid. Passport is part of an integrated system of providers. Specific funding is provided to the University of Louisville for programs that help offset some the costs for education, but most of the funding comes from hospitals providing academic support for the University's School of Medicine that supports the training program. The challenge is getting primary care physicians, allied health professionals, and others to locate in rural areas as opposed to urban areas of the state.

In response to questions by Representative Bowling, Mr. Carter stated that rates are set on a per member per month basis based upon the category of aid that an individual member would fit it. No average rate is used universally across the board. Representative Bowling asked that Passport provider the committee with information on specific rates and how the rates are set. Mr. Lamoreaux and Mr. Payne stated that they would provide the committee information on region-specific profitability or net losses. Mr. Duke stated that he did not have information by regions, but as a whole Humana CareSource is not operating in a profit. Mr. Lamoreaux stated that the vast majority of Anthem's administrative costs are spent in Kentucky and are not allocated back to the other 14 Medicaid plans in other states. Mr. Payne stated that Aetna's administrative dollars are earmarked for Kentucky. Mr. Duke stated that the vast majority of Humana's administrative dollars are spent for Kentucky Medicaid.

Representative Moser stated that there is not allot of predictability in contracts and transparency and barriers to prior authorization, durable medical equipment, and

overutilization of emergency rooms. If providers have to be reimbursed adequately or there will be no one left to provide services to Kentucky's citizens.

Senator Alvarado stated that he will submit questions in writing to the MCOs and wants written responses to the questions. Oversight of the MCOs is the cabinet's responsibility.

Legislative Hearing on Executive Order 2019-028 Relating to Reorganization of the Kentucky Board of Emergency Medical Services

Due to concerns by the Kentucky Board of Emergency Medical Services, Executive Order 2019-028 was deferred to the next meeting.

Adjournment

There being no further business, the meeting was adjourned at 1:08 p.m.