MEDICAID OVERSIGHT AND ADVISORY COMMITTEE

Minutes

December 12, 2018

Call to Order and Roll Call

The Medicaid Oversight and Advisory Committee meeting was held on Wednesday, December 12, 2018, at 1:30 PM, in 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: Senator Ralph Alvarado, Co-Chair; Representative Kimberly Poore Moser, Co-Chair; Senators Danny Carroll and Stephen Meredith; Representatives Jim Gooch Jr. and Melinda Gibbons Prunty.

Guests: Jill Hunter, Senior Deputy Commissioner, Stephanie Bates, Deputy Commissioner, Dr. Gil Liu, Medical Director, and Carl Ishmael, Director of Program Integrity Division, Department for Medicaid Services, Cabinet for Health and Family Services; Elizabeth Caywood, Deputy Commissioner. Lisa Dennis, Chief of Staff, and Kevin Newton, Budget Director, Department for Community Based Services, Cabinet for Health and Family Services; Dr. Mark Jorrisch, MD, Immediate Past President, Kentucky Society of Addiction Medicine; Amanda Hahn, ACLU of Kentucky, Peer Support Counselor; Carolyn Sketch-Basford, RRT, Clinical/Sales Manager, Pulmonary Partners, Kentucky Medical Equipment Suppliers Association; Mike Downing, President, RSVP Home Care, Kentucky Medical Equipment Suppliers Association; Gretchen Davis, Executive Director, Muhlenberg County Opportunity Center; Jane Stahl, Advocate; Amanda Stahl, Social Worker, Advocate; Jamie Hurt-Mueller, CDO Eligibility Coordinator Bluegrass Area, Agency on Aging and Independent Living, Bluegrass Area Development District; Rebecca Cheek, Director of Pharmacy, Grace Health; Milt Gardner; Alecia Fuller, Senior Case Manager, Centerstone of Kentucky; and Heidi Schissler, Kentucky Protection and Advocacy.

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

Approval of Minutes

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

Durable Medical Equipment Reimbursement

Mike Downing, President, RSVP Home Care, Kentucky Medical Equipment Suppliers Association, stated that his durable medical equipment (DME) business is having

issues with the Kentucky Medicaid managed care organizations' (MCOs) unfair practices and constant inconsistencies. His business must follow a different set of rules for each of the five MCOs and Medicaid in regards to prior authorizations. He would like to see all the MCOs and Medicaid follow one set of rules and standards. He would like those rules to be accessible to all without charge. He would like to have consistency across the MCOs regarding prior authorizations' required documentation to provide a continuation of services if a member changes their plan.

He is asking for reimbursement at 100 percent of the Medicaid fee schedule that is common practice in other states. Medicaid has established a fee schedule that it deemed was appropriate and affordable to the state. DME providers are constantly being asked to provide more documentation and are subject to more audits. These reviews are costly to the business and prohibit the DME provider's ability to provide for patients. MCOs are proposing to pay DME providers 65 to 90 percent of the allowable costs which is unsustainable for any business. He would like the Kentucky Department for Medicaid Services (DMS) to establish an equal period of time for recoupment of monies that are done through audits so that the provider has the same time period to rebill or refile a claim.

Carolyn Sketch-Basford, RRT, Clinical/Sales Manager, Pulmonary Partners, Kentucky Medical Equipment Suppliers Association, stated that Medicare and Medicare Advantage plans provide at least the set amount, quantity of supplies, and the services that traditional Medicare would pay for to the providers. She would like see Medicaid follow that example.

Stephanie Bates, Deputy Commissioner, Department for Medicaid Services, Cabinet for Health and Family Services (CHFS), stated that 2018 Regular Session House Bill 69 and the Department of Insurance (DOI) medical necessity criteria, that will be procured, will help to address the rules and consistency issues in regards to documentation for prior authorizations among the MCOs. Per the contracts with the MCOs, when a member switches from fee-for-service to managed care, the MCOs must honor the previous prior authorization for 90 days. Each provider must negotiate their own rates in the contracts with the MCOs. DMS wants to address the issue of the DME providers not feeling that they have the option to negotiate with the MCOs. DMS cannot contractually require the MCOs to pay the same rates as fee-for-service plans. The MCOs are only required to cover the minimums that are set in regulations and statutes. There are two types of recoupments; eligibility recoupments and medical necessity recoupments. Eligibility recoupments are in regards to timely filings. Medical necessity recoupments ask for documentation that prove the information given for the prior authorization is true and there are appeal rights.

In response to questions and comments from Senator Alvarado, Mr. Downing stated that Medicare has three different types of reimbursement rates and is difficult to compare it to Kentucky Medicaid. In January, the Cures Act was passed federally and mandated that

states review the fee schedules. Kentucky lowered rates to mimic the federal rates. Ms. Bates stated that reimbursement amounts are negotiated between the provider and the MCOs. DME providers are different because they are at the mercy of the order of the physician or whoever is ordering the service or product that they would provide. DMS is aware of the negotiation issues between MCOs and DME providers. Mr. Downing stated that there is moral and legal liability for a DME provider to continue services for a member. He would need a discontinuance order from the physician before legally removing oxygen from a patient. Ms. Bates stated that the fee schedule was originally meant for the fee-for-service plan. Providers who are not following the rules are causing problems for good providers.

In response to questions and comments from Senator Meredith, Ms. Bates stated that House Bill 69 regarding credentialing was passed in the 2018 Regular Session. DMS wants to review and change the way MCOs report on DME providers. DMS hopes to require that if the physician sees the patient one time a month in a rural county that it does not count as a fulltime equivalent for a physician. MCOs will have to have fulltime equivalent to meet the access and availability standards.

In response to questions and comments from Senator Carroll, Mr. Downing stated that in the contracts that he has reviewed, the MCOs are using a percentage of a fee schedule. MCOs are paying the lesser of a percentage of the Medicaid allowable, a percentage of the Centers for Medicare & Medicaid Services (CMS) allowable, or a percentage of the Medicare allowable. Providers are left to guess as to what they will apply to that claim or who will review the claim for prior authorizations. Providers do not know the result of the prior authorization until payment or non-payment of the claim. The same issues are not only affecting DME providers but all providers working with MCOs.

Presentation on Behavioral Health and Medicaid Managed Care Organizations

Gretchen Davis, Executive Director, Muhlenberg County Opportunity Center, stated that the Muhlenberg County Opportunity Center is a nonprofit center that has served intellectually disabled adults for over 50 years. The waiver program for people with intellectually disabilities has a waiting list with thousands of people. In the rural county of Muhlenberg, only nine people qualified for the waiver services. The center could not operate with only nine people. She was made aware of regulations under 907 KAR Chapter 15 that helped the center to become a behavior health multispecialty group and could serve more people through this facet of Medicaid. To participate a client must have an intellectual disability with documentation of an additional psychiatric diagnosis. The comprehensive community support services allow people to live with maximum independence in their communities. In the program, a community support associate works with each individual to address all of the goals and needs of the client.

It took approximately 90 days to be approved to become an agency with Medicaid. There were no checklists or instructions, it was trial and error when moving forward for

the approval. After the Medicaid approval, she was told the center must contract with each of the five MCOs. She started the process in February and as of December she only has contracts with two of the five MCOs. She shared her process timeline with the committee. She has waited months and weeks for people to return her phone calls. The EXPLORE programs stands for Exceptional People Learning, Observing and Receiving quality life Experiences. The center hopes to help their clients to learn to work and make a decent wage. In Muhlenberg county about 20 to 30 special needs children graduate each year and are not being placed anywhere. The center has three goals for all their clients that include community access, health, and vocational options.

In response to questions and comments from Representative Moser, Ms. Davis stated that the center is established through behavioral health classifications instead of the waiver programs. Clients must have an intellectual disability plus a psychiatric diagnosis to participate in the program at the Muhlenberg County Opportunity Center. There is no regulation regarding a time limit at the center. Clients are at the center from 24 to 40 hours a week depending on what they are doing with their mentors. The center was told that people who had applied for waivers could have a possible seven year wait for waiver approval.

In response to questions and comments from Senator Alvarado, Ms. Davis stated that the goal of the Muhlenberg County Opportunity Center is to assist and train the clients so they will be able to leave the sheltered workshop and maintain employment in the community. The center varies its program when working with younger and older clients. The center would like to start their own shredding business for better employment opportunities for their clients.

Update on Medicaid Credentialing

Carl Ishmael, Director, Program Integrity Division, Department for Medicaid Services, Cabinet for Health and Family Services, stated that if there are any complaints that providers cannot get enrolled into Medicaid to forward the provider's information and issue to him. On average DMS receives 600 to 800 new provider applications a month. DMS has approximately 43,000 enrolled Medicaid providers. DMS also receives approximately 3,000 maintenance items from providers such as change of address, new physician to new practice, and bank account changes. DMS is working on an online, automated enrollment system to streamline the system called Partner Portal. CHFS has dedicated substantial resources into working through the requirements for 2018 Regular Session House Bill 69 and developing the request for proposal (RFP). There is not date set as to when the RFP will be released. The Program Integrity Division is working with the Center for Program Integrity (CPI) through CMS that also provides oversight for provider enrollment.

In response to questions and comments from Representative Gibbons Prunty, Mr. Ishmael stated that the use of the Partner Portal program that is in pilot, may have helped

to eliminate some of the issues for Ms. Davis. The enrollment process is still a manual process but CHFS is working to automate the process. The Program Integrity Division would like to encourage providers to contact their offices with the providers NPI and address, if it has taken longer than 90 to 120 days to get enrolled with Medicaid. The Program Integrity Division would like to review the issue and process to get the issue resolved.

In response to questions and comments from Senator Alvarado, Mr. Ishmael stated that the 600 to 800 new provider applications a month cover the spectrum of the different types of providers. There is typically an influx of applications when physicians graduate in a large group.

Backlog on Child Abuse and Neglect Checks for Participant Directed Services

Amanda Stahl, social worker, disability advocate, waiver recipient, stated that she has been working as a social worker and hiring her own staff for 14 years. Since September 2018 she has struggled to get completed Child Abuse and Neglect (CAN) registry checks for potential staff back from CHFS. She is down to only two employees, one of which is her mother. Although she loves her mother, she would prefer her mother not be one of her employees. She has a full time job as a social worker and tries to inspire people to be independent and active. It is important to her to be able to hire her own staff to help her with her every day, personal care matters. She does not want to hire her personal staff through an agency or go into a nursing home. However, she may be forced to do so if the CAN registry checks are not completed in a timely manner.

Jane Stahl, mother, advocate, stated that Amanda Stahl did receive the criminal background check and an adult abuse registry check back on her potential hire but the CAN registry check that has not been returned is inhibiting her from hiring staff.

Alicia Fuller, Senior Case Manager, Centerstone of Kentucky, stated that the purpose of the Michelle P. Waiver is to provide funding for caregivers to work with participants to help them develop independent living skills. The recipients of the Michelle P. Waiver are not receiving the support they need because of the delay in processing the CAN registry checks. She has a client that has been without services through the Michelle P. Waiver due to the delays in processing the background checks. Per the Michelle P. Waiver regulations, caregivers are unable to work until the results of the CAN registry check are received. The CAN registry check results are taking between 80 and 85 days. Centerstone of Kentucky has 59 outstanding CAN registry checks due for participants of the Michelle P. Waiver. Centerstone of Kentucky has a total of 115 CAN registry checks due over all waivers. On behalf of the waiver participants, Centerstone of Kentucky asks that steps be taken to reduce the processing time so that clients can receive the crucial supports they need daily to live independently.

Jamie Hurt-Mueller, CDO Eligibility Coordinator, Agency on Aging and Independent Living, Bluegrass Area Development District, stated that her agency is having similar waiting periods for CAN registry checks. It is taking an average of 75 days to receive a CAN registry check back when in July it was taking two weeks. On Michelle P. Waiver staff are not allowed to work at all until they have been are approved by all registry checks. For the Home and Community Based waiver (HCB) and the Supports for Community Living (SCL) waiver, an employee can work for 30 days but must have all background checks approved to continue as staff. It is a problem for the waiver recipient and the employee. She has clients that are in emergency need of staff but was told by CHFS staff there are hundreds that are in emergency need of approval and her clients could not be found. Waiver participants are being negatively impacted waiting months for a CAN registry check to come back.

Jill Hunter, Senior Deputy Commissioner, Department for Medicaid Services, Cabinet for Health and Family Services (CHFS), stated that DMS is working as a team with the Department for Community Based Services (DCBS) to reduce the backlog of CAN registry checks.

Elizabeth Caywood, Deputy Commissioner, Department for Community Based Services, Cabinet for Health and Family Services, stated that DCBS realized the backlog was problem as a result of Senate Bill 236 passed in the 2017 Regular Session. All public school personnel are required to have a CAN registry check, unfortunately most schools waited until spring and summer to submit the checks creating a backlog. The CAN registry check is a paper-based, manual process. Unfortunately DCBS has not had the resources to invest in technology for automation of the checks. Since spring DCBS has dedicated staff across the state and pulled in volunteers to conduct the CAN registry checks, despite best efforts DCBS has not met the demand. DCBS is intensifying those efforts with interim staff, additional state staff, as well as more volunteers from within CHFS to help staff the process. The wait time for a CAN registry check is approximately 70-75 days.

DCBA has a project underway that will allow for electronic application and payment but is four to six months out from being implemented. The Kentucky State Police is planning to set up an electronic fingerprinting process. DCBS is partnering with KSP to review how its proposed vendor is working with other states to incorporate the central registry within its process. DCBS has the leadership at the top of the department and cabinet very much vested in short and long term solutions to this problem.

Discussion on Prior Authorization for Medication-Assisted Treatment for Addiction

Dr. Gil Liu, Medical Director, Department for Medicaid Services, Cabinet for Health and Family Services, stated that the chart he supplied to the committee shows the previous three year annual trends in Medicaid enrollment and statistics regarding Opioid Use Disorder (OUD) trends. The Medicaid expansion population has climbed a small amount but the population with opioid use disorder has climbed dramatically over the same

period of time. The expenditures associated with care for those with OUD is growing. In 2019, among the 39,000 Medicaid beneficiaries with OUD, claims suggest that 23,000 have evidence of receiving medication assisted treatment (MAT). There are many concerning harms of OUD, one of those is that a mother with OUD complicates her pregnancy by delivering an infant who experiences neonatal abstinence syndrome (NAS). A relatively small fraction of women who are recognized as having OUD are receiving treatment during pregnancy. In 2018 there were 900 cases of NAS.

A quality indicator when treating someone with OUD when you are including medications is random toxicology screenings. When using MAT, 82 percent of cases have evidence of on-time toxicology screening. All individuals who visit an emergency department for OUD should have a close follow-up visit to bridge the patient into treatment. There are very low rates of follow up within a week. DMS expects to spend around $15,600 per year on a member with a diagnosis of OUD in contrast to $3,700 on those without OUD. MAT is the number one evidence based means of reducing deaths from OUD. The MCOs' rate of prior authorization denial for buprenorphine is 15 percent. Denial of buprenorphine is often for inadequate medical documentation to justify the medical necessity of that treatment.

Dr. Mark Jorrisch, MD, Immediate Past President, Kentucky Society of Addiction Medicine, stated that the OUD crisis is not going away. OUD is increasing and people continue to die. The brain disease of OUD with a known biology is best treated with MAT, specifically with buprenorphine, Suboxone, and methadone. OUD is best treated as a chronic medical illness similar to how other chronic medical illnesses are treated. Affordability and accessibility are barriers that prevent patients from entering treatment in a timely manner. Limitations that affect prescribing, dosing, length of treatment, settings for treatment, formulations of the medications, and required associated services should not interfere with the ability to provide office based treatment with buprenorphine.

Amanda Hahn, Peer Support Specialist, ACLU of Kentucky, stated that MAT saves lives and families. The barriers with prior authorizations are keeping people with OUD from getting treatment in a timely manner. She believes the state is moving forward to help Kentuckians.

In response to questions and comments from Representative Moser, Dr. Liu stated that he believes that the emergency provisions that are being put into place by the MCOs will be permanent. Two MCOs have piloted preferred providers arrangements where there is no prior authorization for preferred providers. DMS is also designing a preferred provider arrangement. There continues to be patterns with inappropriate prescribing of antimicrobials and antipsychotic to children. A preferred provider not only dispenses medication but makes behavior health services, counseling, peer support, employment support, and programs to address community factors available to patients with OUD. A

preferred provider would have to make a commitment to reporting on the quality of their services.

Adjournment

There being no further business, the meeting was adjourned at 3:35 PM.