

MEDICAID OVERSIGHT AND ADVISORY COMMITTEE

Minutes

July 8, 2019

Call to Order and Roll Call

The Medicaid Oversight and Advisory Committee meeting was held on Monday, July 8, 2019, at 1:00 PM, in Room 171 of the Capitol Annex. Senator Stephen Meredith, Chair, called the meeting to order, and the secretary called the roll.

Present were:

Members: Senator Stephen Meredith, Co-Chair; Representative Daniel Elliott, Co-Chair; Senators Ralph Alvarado, Danny Carroll, Jimmy Higdon, and Morgan McGarvey; Representatives Jim Gooch Jr., Melinda Gibbons Prunty, Steve Sheldon, and Lisa Willner.

Guests: Carol Steckel, Commissioner, Jessin Joseph, Pharmacy Director, Department for Medicaid Services, Cabinet for Health and Family Services; Don Kupper, President, Kentucky Pharmacists Association; Trevor Ray, PharmD, Independent Pharmacist, Owner, Midway Pharmacy; Betsy Johnson, President, Executive Director, Wayne Johnson, Vice President of Reimbursement, Kentucky Association of Health Care Facilities, Kentucky Center for Assisted Living; Melanie Claypool, Director, Provider Network, Passport Health Plan; Shawna Dellecave, Director, Family Advocacy and the Arts, The Council on Development Disabilities; and Erin Davis, Executive Director, The Prince Care Group.

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

Approval of Minutes

A motion to approve the minutes of the June 3, 2019 meeting was made by Representative Sheldon, seconded by Senator Alvarado, and approved by voice vote.

Independent Pharmacy Reimbursements

Don Kupper, President, Kentucky Pharmacists Association (KPhA), stated that along with the American Pharmacy Services Corporation, the KPhA represents more than 6,000 pharmacists. The KPhA works to ensure fair, adequate, and transparent pharmacy reimbursements for Kentucky pharmacies. The passage and implementation of the 2018 SB 5 along with a two dollar dispensing fee increase were important steps for Kentucky pharmacies.

Trevor Ray, PharmD, Independent Pharmacist, Owner, Midway Pharmacy, stated that the National Average Drug Acquisition Cost (NADAC) is a federally developed survey of community pharmacies to determine the average acquisition cost for outpatient prescriptions drugs dispensed in Medicaid. The NADAC is a component in reimbursement methodology in the Kentucky Medicaid fee-for-service program. The Centers for Medicare and Medicaid Services (CMS) recommends a professional dispensing fee between \$9 and \$13 based on acquisition costs. Effective rate contracting is a pharmacy benefit manager (PBM) reimbursement methodology where pharmacists are guaranteed a certain reimbursement level on a group of drugs that are dispensed over a period of time. Spread pricing is the difference between the amount paid by the health insurance plan to the PBM and what the PBM reimburses pharmacies.

In June of 2017, pharmacies saw dramatic drops in reimbursements from the Medicaid Managed Care Organizations (MCOs). SB 5 originally would have required the Department for Medicaid Services (DMS) to directly administer pharmacy benefits, commonly referred to as a carve-out. The carve-out is the most transparent, fair, and predictable method for pharmacy reimbursement. The House amended SB 5 to remove the carve-out provisions and added transparency, data collection requirements, and other pharmacy reimbursement restrictions. SB 5 provisions include requiring the PBMs to submit pharmacy reimbursement data to DMS and giving DMS the authority to review and approve reimbursement rates over or under five percent 30 days before a change is said to take effect. SB 5 permits DMS to set, create, or approve the PBM established pharmacy reimbursement rates and to require the PBMs to comply with all state and federal laws.

The dispensing fee to pharmacies has increased by two dollars. Data analysis was conducted by DMS that resulted in transparency recommendations, methodology changes, and increased accountability for the MCOs and PBMs. DMS has acted to stop the reduced reimbursements on high-frequency dispensed drugs. Community pharmacies have developed a more positive working relationship with DMS. However, there are still MCO reimbursement issues with spread pricing, lack of transparency in pharmacy reimbursement data, lack of regulation implementing the SB 5 provisions, PBMs utilizing the effective rate contracting practices, specialty pharmacies, mail order pharmacies, national contracts, accountability, and fees. A Kentucky Medicaid data report concluded that \$209 million was paid to PBMs by MCOs that was not paid to pharmacies over the past two years.

The use of effective rate contracting will continue to add to the disruption of transparency. Pharmacies are unsure of how much will be paid at the end of the year due to post adjudication fees, recoupments, effective rate adjustments, claims processing fees, and other fees charged by the PBMs to pharmacies that lower the overall pharmacy reimbursement. Independent pharmacies are seeing retail claims that follow the NADAC methodology with a small \$.30 to \$.50 cent dispense fee instead of the recommended \$9 to \$13. The PBMs frequently mandate that patients receive specialty drug prescriptions from

specialty pharmacies that are owned by the PBM and likewise with mail-order prescriptions.

The PBMs are not direct contractors with the state and it can be difficult for regulators to hold the PBMs accountable for its actions. The large number of fees the PBMs charge pharmacies continue to be disruptive to the overall reimbursement rate. Six states, including Kentucky, reported more than \$865 million healthcare dollars lost to spread pricing. Ohio has implemented pass-through contracts and is seeing increased reimbursements but still not enough to cover the cost of doing business. Data reported to the federal government does not include spread pricing. In July of 2017, West Virginia implemented a Medicaid carve-out plan. A West Virginia study showed a savings of \$54 million. Prior to the carve-out, West Virginia paid \$66.8 million in administrative expenses to the MCOs for pharmacy benefits. After the carve-out, West Virginia's administrative expenses dropped to \$9.9 million.

The new request for proposal (RFP) for the MCOs' contracts contains positive improvements such as mandating pass-through contracts, prohibiting post-adjudication fees, including effective rate contracts, and an increased dispensing fee. Suggested additional improvements to ensure greater transparency would be to prohibit national contracts and to require each MCO to contract with each pharmacy without the bundling of other contracts. DMS could set the reimbursement rates for all MCO plans and mandate that the MCOs hire a transparent PBM or mandate that DMS directly administer pharmacy benefits. Independent pharmacies would also like to see an increase in the dispensing fees to adequately reimburse the pharmacies for the services provided. Pharmacies will continue to work with Medicaid to implement its full authority to set, create and approve reimbursement rates.

In response to questions and comments from Senator Higdon, Mr. Ray stated that DMS could mandate that the MCOs have an individual contract with pharmacies and not a bundled national contract. DMS is working with the independent pharmacies to figure out how to be proactive and gain more control of the PBMs in the proposed MCO contracts.

In response to questions and comments from Senator Alvarado, Mr. Ray stated that there are some collusion issues that could arise if pharmacy groups under different ownerships decided to share pricing information. Pharmacy services administration organizations (PSAOs) may have the ability to leverage and negotiate the PBMs' contracts. However, there is not much leverage because the PBMs are so much larger than any of the pharmacies, even the ones in a PSAO. Small and rural independent pharmacies do not have the ability to negotiate and leverage MCO contracts. At times the MCOs are not aware that the PBM has made changes until notice is given by the pharmacies. Pharmacies are not given a reason or explanation as to why a reimbursement has been changed. Once an appeal has been filed with the Department of Insurance by a pharmacy regarding a reimbursement, the reimbursement will be increased in many cases but it is an arduous process. Mr. Kupper

stated that many patients in the eastern and rural part of the state would not have any other way to receive medications if not through Kentucky Medicaid.

In response to questions and comments from Representative Gibbons Prunty, Mr. Ray stated that independent pharmacies do not have a reasonable explanation as to why there are so many fees paid to the PBMs by the pharmacies. Many of the fees are added for participation in a network. At times the recoupment retroactive fees are not seen until six months after the prescription has been filled. The additional fees have gone up 45,000 percent in the last six years.

In response to questions and comments from Representative Sheldon, Mr. Ray stated that cash prescriptions are the only type of prescriptions where a total amount paid is known at the point of sell. Cash prescriptions are less than 10 percent of a pharmacy's business.

In response to questions and comments from Senator Carroll, Mr. Ray stated that the MCOs would know what the process is for dropping a medication from a formulary prescription list. Many times the provider will need to complete a long process to receive a prior authorization for the medication. Independent pharmacies will continue to work with DMS and legislators to receive fair payment for the products and services provided to patients.

In response to questions and comments from Senator Meredith, Mr. Ray stated that there are many hospitals as contract entities that are sponsors of the 340B drug pricing program with rural and chain pharmacies. There are also rural health clinics that are involved with the 340B drug pricing program.

Implementation of 2018 RS Senate Bill 5

Jessin Joseph, Pharmacy Director, Department for Medicaid Services, Cabinet for Health and Family Services, stated that DMS has been monitoring the pricing spread through May of 2019. As part of SB 5, all MCOs and PBMs are required to give the cumulative spread to DMS on the fifteenth of the month. At 12.92 percent, the spread has stayed the same as it was at the end of 2018. WellCare does not have a spread because the contractual model that they have is an administrative fee model or a pass-through model, which is based off a flat fee per member, per month or per claim depending on the contract. The other four MCOs' spread is what is charged to DMS compared to what is reimbursed to pharmacies. In other states, the spread averages around 8 to 15 percent.

Many changes were made to the new RFP for the MCOs' contracts that came from discussions with independent pharmacists and organizations to better understand what is happening at a ground level of business. DMS referenced the Kentucky statute specific to SB 5 in the RFP. The reporting requirements would be contractual. DMS would require a report of the spread. DMS modified the requirements to reinforce that the MCOs would

have to align coverage, prior authorization criteria, and processes to those of DMS. The pharmacy rebate language was added to the RFP to ensure MCOs comply. DMS put in the RFP that the PBMs must use a pass-through model for payments to the pharmacies. DMS removed the MCOs' and PBMs' ability to charge hidden fees such as retroactive take-backs from the pharmacies, generic effectiveness rates, and the direct and indirect remuneration fees. DMS removed the previous barriers to receiving both the summary and claim-level detailed pharmacy reports from the MCOs and PBMs.

SB 5 requires any changes greater than five percent in the aggregate or at the point of sale to be reported to DMS. DMS has been developing the maximum allowable cost (MAC) rate change monitoring process. The MAC changes daily and a goal of DMS is to have an automated system. DMS uses an algorithm, along with NADAC, wholesale acquisition cost (WAC), and average wholesale price (AWP), to justify the reasoning behind the change in the rate of a prescription. DMS is working with vendors to monitor drug price changes at the national level for approvals and denials of the rate changes.

Carol Steckel, Commissioner, Department for Medicaid Services, Cabinet for Health and Family Services, stated that DMS is working on replicating the West Virginia study with Kentucky data. DMS hopes that by the fall of 2019, it will be able to share data regarding what the impact would be if a carve-out was done or not. DMS has control over the PBMs and will build that power in the new contracts. DMS held the MCOs accountable to obtain data regarding PBMs. DMS is meeting with representatives from the independent and chain pharmacies to hear about the current issues and concerns. DMS is working to create a level and fair playing field for the independent pharmacies.

Mr. Joseph stated that all MCOs are required to utilize a pharmacy and therapeutic (P&T) committee similar to the fee-for-service population. As new drugs come to the market, DMS asks the P&T committee to evaluate the drug. The recommendations from the P&T committee often align with what the MCOs have on the preferred drug list (PDL). For best efficiency, DMS would prefer a state mandated, single PDL that all MCOs would abide by to relieve the burdens from providers. DMS is working on uniform policies which will help the MCOs and PBMs to administer care. Commissioner Steckel stated that DMS is working hard to prevent unintended consequences. DMS may appear to be slow to respond but DMS is working closely with all pharmacists, MCOs, and PBMs while being mindful of the impact on the community pharmacists.

In response to questions and comments from Senator Meredith, Commissioner Steckel stated that the anticipated shortfall of \$200 million did not occur within Kentucky Medicaid. Kentucky Medicaid is close to having a level budget because there has been a significant decrease in the number of eligibles. The primary provision of SB 5 was the five percent rate increase or decrease that has been implemented and is being monitored by DMS. DMS is seeing an evolution of the issues. The next issue to be addressed is the post

adjudification adjustments. DMS will not be able to see results in that area until the new MCO contracts become effective on July 1, 2020.

In response to questions and comments from Senator Higdon, Commissioner Steckel stated that in regards to the MCOs contract update, DMS has disclosed all the information that is permitted. Questions regarding the RFP should be directed to the Cabinet of Finance and Administration. The new MCO contracts will begin on July 1, 2020.

In response to questions and comments from Senator Alvarado, Commissioner Steckel stated that the West Virginia program was very different from the Kentucky program. West Virginia had a carve-out, a single PDL, and the organization of its program was different. West Virginia has approximately half the number of people on Medicaid as Kentucky. DMS is replicating the West Virginia data with Kentucky Medicaid numbers so there is a more accurate comparison. DMS is pulling data in regards to expected profitability of the insurance companies and to verify if the money is returned to the MCOs as part of the medical loss ratio (MLR). In 2016, DMS started the MLR. It is DMS' intent to evaluate and adjust the MLR back to 2016 to reflect any errors in calculating the MLR given the PBMs' rates.

Long-Term Care Facilities Status Report

Betsy Johnson, President, Executive Director, Kentucky Association of Health Care Facilities (KAHCF), Kentucky Center for Assisted Living (KCAL), stated that KAHCF is the primary association that represents propriety and nonproprietary nursing facility providers, personal care homes, and assisted living communities across Kentucky. In regards to long-term care, only skilled nursing facilities receive Medicaid reimbursement. Assisted living providers and personal care providers do not receive Medicaid reimbursement for services provided. Nursing facility providers serve approximately 31,000 residents and account for 57,470 direct and indirect jobs statewide. There is at least one nursing facility in all of the 120 counties in Kentucky. Medicaid recipients make up almost 70 percent of residents in skilled nursing facilities in Kentucky. The impact of nursing facilities is shown in terms of jobs, income, economic activity, and tax revenue contributed to the state. Long-term care providers support an estimated \$5.13 billion of the state's economic activity.

Wayne Johnson, Vice President of Reimbursement, Kentucky Association of Health Care Facilities, Kentucky Center for Assisted Living, stated that nursing facility providers have faced unprecedented general and professional liability costs in the past due to predatory trial attorney practices and the litigation environment in Kentucky. Obtaining a qualified workforce has gotten more difficult for nursing facility providers. The current low unemployment rates, lack of workers, and the competition in other health care fields have driven up wages significantly. The nursing facility acuity rate in Kentucky remains high as providers care for the most fragile citizens. A 2018 AON Report highlights

Kentucky as one of the worst states in need of medical malpractice reform and is lagging in tort reform.

Between 2010 and 2030 Kentucky's population over age 65 will increase by 72 percent and this will increase the demand for Certified Nursing Assistants (CNAs), Licensed Practical Nurse (LPNs), and Registered Nurses (RNs). Statewide RNs, LPNs, and nurse aide wage costs have steadily increased over the past 10 years. Although providers received a full inflationary increase this year, Medicaid increases have not kept pace with these and other staff increases. Nursing facility providers in Kentucky have higher levels of staff when compared to surrounding states. Kentucky continues to give the direct care needed to provide quality within the state. Since 2010, Medicaid and total patient acuity has risen dramatically.

Long-term care facilities are reimbursed by Kentucky's Medicaid Program through a price-based system implemented by DMS in 2000. The urban and rural prices are adjusted quarterly for acuity and annually by an inflationary adjustment determined by DMS. In theory, the price-based system allows DMS to accurately predict nursing facility costs. Although DMS will increase provider rates by the full inflationary increase effective July 1, 2019, providers have only been paid one-tenth of one percent inflation for the past five years. Due to the inflationary rates paid over the past five years, KAHCF proposed a provider tax increase to fund an inflationary increase. Last year's proposal would have increased taxes by \$.93 per non-Medicare day, providing a net of \$17.8 million in revenue to nursing facility providers. KAHCF, KCAL, and providers have tried to offer solutions to problems presented to the profession. The current cost and reimbursement environment in Kentucky is critical.

In response to questions and comments from Senator Meredith, Ms. Johnson stated that the federal law allows up to a six percent provider tax for skilled nursing facilities however there is a state statute that caps that provider tax at 4.2 percent. Skilled nursing facilities would pay the provider tax up front then be matched with federal dollars. There would not be any general fund dollars required for the skilled nursing facilities across Kentucky to see approximately \$20 million in additional reimbursements. Mr. Johnson stated that as of last year, Kentucky has an 87 percent occupancy bed rate. Traditionally, Kentucky has a higher occupancy rate than other surrounding states.

In response to questions and comments from Senator Carroll, Ms. Johnson stated that in regards to quality, there has not been much improvement however, Kentucky is above the national average on short-term readmissions to hospitals. In regards to the survey environment, Kentucky nursing facilities are the most cited in the nation for immediate jeopardies and fined the most in civil money penalties. There is \$33 million in a civil fund that is not being put back into the economy or resident care. The chair of KAHCF has created a data workforce committee to review data to understand why Kentucky is falling short with immediate jeopardies being issued against providers. If a skilled nursing facility

is cited with an immediate jeopardy the nursing facility is no longer able to train nurse aides in the facility causing workforce issues. Mr. Johnson stated that in Kentucky the average fine is nearly \$100,000 per facility. The national average is approximately \$90,000.

In response to questions and comments from Representative Gooch, Ms. Johnson stated that the provider tax would be on the licensed skilled facility beds. Federal law requires that all like providers are taxed the same if participating in the provider tax system. The provider tax system would benefit the majority of the skilled nursing facilities in Kentucky. Mr. Johnson stated that the provider tax is based on non-Medicare days rather than a per bed tax. The provider tax change proposed to DMS is an incremental provider tax.

In response to questions and comments from Senator Alvarado, Ms. Johnson stated that nursing facilities staff turnover rate is a significant issue. The KAHCF has a human resources committee within the association to assist providers in dealing with workforce issues. CMS changed the criteria for the star rating system for nursing facilities. The health inspections provide the most weight on the star rating that deal with the requirements of participation set by CMS. If a nursing facility receives an immediate jeopardy or has a bad health survey, it takes approximately three years to get the star rating back up. Kentucky's average for short stay readmissions was better than the national average but in other areas, such as quality, Kentucky is in the middle of the national average. Kentucky is an outlier in the immediate jeopardy category. Kentucky is number two in the nation in regards to litigation.

In response to questions and comments from Senator McGarvey, Ms. Johnson stated that KAHCF hoped to collect data regarding the medical review panel legislation but it was not possible due to the Kentucky Supreme Court decision. KAHCF will be watching the implementation of the certificate of merit bill passed in the 2019 Regular Session. The KAHCF will work closely with the Kentucky Justice Association. The KAHCF will review what is working for other states in regards to tort reform. The KAHCF hopes to address the way that nursing facilities are targeted and the amount of records requests that are put on the facilities by trial attorneys. The KAHCF is not seeking to limit legitimate, rightful settlements or litigation due to egregious behavior of providers.

Provider Tax for Long-Term Care

Carol Steckel, Commissioner, Department for Medicaid Services, Cabinet for Health and Family Services, stated that DMS will work with the long-term care industry on increasing the provider tax to provide more of a federal match. DMS does want to review the data regarding providers that do not take Medicaid or providers that have a large private pay population and the impact of raising the provider tax in the private market. DMS wants to maximize resources for all providers.

In response to questions and comments from Senator Meredith, Commissioner Steckel stated that DMS would review using intergovernmental transfers for rural and county hospitals. DMS is in the process of getting approval for graduate medical education and indirect medical education programs with the University of Kentucky and the University of Louisville. The universities would benefit from the programs but would also provide funding to 14 other hospitals in Kentucky that also have graduate medical education programs. DMS is meeting once a week with the Kentucky Hospital Association (KHA) regarding the implementation of House Bill 320 which is a hospital assessment. DMS is looking at the market as a whole to maximize resources for all providers.

Adjournment

There being no further business, the meeting was adjourned at 3:04 PM.