MEDICAID OVERSIGHT AND ADVISORY COMMITTEE

Minutes of the Meeting of the 2020 Interim

October 28, 2020

Call to Order and Roll Call

The meeting of the Medicaid Oversight and Advisory Committee was held on Wednesday, October 28, 2020, at 3:00 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; Senators Ralph Alvarado, Danny Carroll, Jimmy Higdon, and Morgan McGarvey; Representatives Jim Gooch Jr., Melinda Gibbons Prunty, Steve Sheldon, and Lisa Willner.

Guests: Lisa Lee, Commissioner, Department for Medicaid Services, Leslie Hoffman, Chief Behavioral Health Officer, Department for Medicaid Services, Alisha Clark, Assistant Director, Division for Community Alternatives, Department for Medicaid Services, Cabinet for Health and Family Services; John Inman, Chief Policy Officer, Teresa Cooper, Director of Government Affairs, Kentucky Primary Care Association.

LRC Staff: Chris Joffrion and Hillary Abbott.

Approval of Minutes

There was a motion to approve minutes made by Senator Carroll and seconded by Representative Gibbons Prunty and was approved by a voice vote.

Medicaid Waiver Redesign

Lisa Lee, Commissioner, Department for Medicaid Services (DMS), Cabinet for Health and Family Services stated that 1915(c) Home and Community Based Services waivers (HCBS) are designed to give individuals with disabilities an alternative to institutionalized care. HCBS waivers are intended to complement available state Medicaid program services, public programs, and family and community supports to meet each individual's needs. HCBS waivers should allow an individual to live safely in the community. If an individual's needs exceed what can be safely provided in the community, waiver services may not be appropriate for the individual. To receive Centers for Medicare and Medicaid Services (CMS) approval for a 1915(c) HCBS waiver, states must provide the same level of care in the community that an individual would receive in an institution, demonstrate that the cost of care in the community is equal or less than an institution or is budget-neutral, and should conduct monitoring to ensure waivers meet quality standards.

Commissioner Lee stated that there are six waiver programs: the acquired brain injury (ABI) waiver; the acquired brain injury long term care waiver for individuals age 18 or older; the HCBS waiver for individuals age 65 or older and individuals of any age with a physical disability; the Model II waiver (MIIW) for individuals dependent on a ventilator 12 or more hours a day or on an active, physical monitored weaning program; the Michelle P Waiver (MPW); and the supports for community living (SCL) waiver for individuals with intellectual or developmental disabilities. In state fiscal year 2019, the HCB waiver served 10,658 participants, accounting for 17 percent of the total paid claims; the MPW waiver served 10,212, accounting for 36 percent of total claims paid; the SCL waiver served 4,921 participants, accounting for 41 percent of total paid claims; the ABI Acute waiver served 296 participants, accounting for 3 percent of total paid claims; the ABI LTC waiver served 263 participants, accounting for 3 percent of total paid claims; and the MWII waiver served 33 participants, accounting for less than 1 percent of total paid claims.

Commissioner Lee stated that in February 2017, DMS issues a request for proposal (RFP) to assess 1915(c) HCBS waiver programs, and in August of 2017, DMS contracted with Navigant to conduct the assessment. The goals of redesign are to enhance the quality of care to participants, implement consistent definitions across waivers, create a universal assessment tool, create individualized billing structures, address cost containment, provide consistent provider funding, and optimize case management to support person-centered planning and abide by federal conflict-free case management regulation. In August of 2018, Navigant delivered its assessment report with recommendations. The redesign activities include implementing ongoing stakeholder engagement processes, streamlining the incident reporting process and moving to an electronic reporting system, switching service authorizations from third-party to case managers, providing updated patient liability calculations, and completing a comprehensive rate study with recommendations for new rate methodology. In January 2020, redesign activates were paused. No date for resuming the project has been set.

Commissioner Lee stated that increasing evidence suggests the cabinet cannot operate as it has historically if it wants to drive value and outcomes for the vulnerable populations served by 1915 (c) HCBS waivers. The need for HCBS reforms could be seen in federal compliance risks, over and underutilization, waitlists, high spending with limited reportable outcomes, and inconsistent policy and oversight history. There is a waiting list for slots in the MPW and SCL waivers. A total of 7,352 individuals are currently on the waitlist for the MPW with an average time elapsed since application processing of 2.9 years. The earliest application processing date for an individual on the MPW waitlist dates back to 2015. A total of 124 individuals are currently on the SCL- urgent request waitlist with an additional 2,729 individuals on the SCL-future planning waitlist. The average time elapsed since application processing is 3.64 years for urgent requests and 7.16 years for future planning. The earliest application processing date for an individual on the SCL-

urgent request waitlist is 2000, and for an individual on the SCL-future planning waitlist it is 1995. The MPW waiver is based on a first-come, first-served methodology, and with lengthy waits for waiver slots, it is essential that both MPW and SCL waitlists are managed using a method that considers an applicant's risk of institutionalization. More robust waitlist management could also provide needed data to report on waitlisted individuals and the extent of their need.

Kentucky spent over $1.5 billion on 1915 (c) waivers in 2016, and Kentucky outpaces the national per capita average spend for 1915(c) waivers. However, the cabinet struggles to demonstrative return on investment or report outcomes. Per CMS reports, Kentucky spent over $1.5 billion on 1915(c) waivers in 2016. Kentucky spends approximately 40 percent more per capita on people with developmental disabilities and approximately 43 percent less per capita on older people or people with physical disabilities compared to the national averages. The cabinet lacks funds to meet current HCBS demand or address future growth in demand.

The Cabinet had identified focus areas for improving program components that pose current federal compliance risks. DMS is initiating waiver renewals with updated waivers and administrative regulations that implement updated rates based on sound rate-setting methodology, improving case management performance, retraining on the assessment tool, and updating independent assessor contractors to promote valid, high-quality needs assessment. Focus is being placed on optimizing critical incident management to observe CMS best practices and advance timely monitoring, investigation, remediation of critical incidents, evaluation options for risk-based waitlist management, and implemented a strengthened inter-agency memorandum of agreement between DMS and operating agencies.

Commissioner Lee stated that steps DMS has taken to improve the HCBS waivers since January 2020 include reviewing rate study findings and recommendations to understand better stakeholder perspectives and the pros/cons of rate recommendations, monitoring the deployment of the secondary authorization process for certain high-cost, high-skilled services, conducting additional analysis of what data is available to understand compliance exposures and inform how to proceed. DMS is continuously engaging stakeholders, reviewing feedback, and expanding access to Medicaid waiver applications to increase care coordination among providers and better track incident reports. DMS began the renewal process for HCB and Model II waivers in the spring of 2020.

Commissioner Lee stated that the projected fiscal impact based of the redesign recommendations ranged from a 26 percent increase to a 14 percent decreased spend across each waiver. The most substantial barrier to the waiver redesign is the service market's dependence on the fee structure. When the waivers were adopted, Kentucky did not yet have its child insurance program (KCHIP) established. The waiver programs could save a great deal of money if the children who are on a waiver, billed for services that are also

covered by KCHIP through KCHIP. Issues with a lack of funding from decades of not altering the waiver program to the current fiscal and community realities had left the program not fiscally efficient. The budgetary impact per capita expenditures for all the waiver programs showed 24,166 individuals served, with a total cost funding per person of $360,292 and a proposed rate funding per person of $358,670. The waiver program would need an additional $137 million to improve the application process and case management across all programs and implement the Navigent recommendations to keep the program in compliance with CMS. Commissioner Lee would like to work with the general assembly to figure out avenues for a fiscally sound waiver redesign. Until a solution to the budgetary issues can be solved, the waiver redesign project is paused.

In response to questions and comments from Senator Carroll, Commissioner Lee stated that the discrepancies in billing through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, is a primary reason why the waiver redesign is paused. Commissioner Lee stated that there is profound pushback from providers in already scantly covered areas to remove the ability to bill through EPSDT instead of through KCHIP since many providers have built their business around those fees. DMS would not move forward until most stakeholders agree and the participants are served the care they deserve. Commissioner Lee stated that Senator Carroll's concerns for the EPSDT billing change are one of the main reasons why DMS would like to request the help of the Medicaid Oversight and Advisory Committee and the General Assembly to figure out the best way forward to make up the $137 million needed to improve and keep the program in compliance with CMS.

In response to questions and comments from Representative Sheldon, Commissioner Lee stated that the waiver redesign should not affect pharmacy benefits.

In response to questions and comments from Senator Alvarado, Commissioner Lee stated there is no timeline for the redesign discussion to start back up again, and looks forward to a task force or legislation to help answer the problems identified in the assessment of the program.

In response to questions and comments, Senator Meredith, Commissioner Lee stated she and DMS would welcome a task force to address the barriers to a waiver redesign.

In response to questions from Representative Prunty, Commissioner Lee stated that the rate difference in EPSDT and KCHIP billing came from the waiver being designed before KCHIP covered those same services for all children and that DMS never reconciled the rates once KCHIP was in place. Commissioner Lee stated she does not know why under previous administrations, DMS did not reconcile the rates. Commissioner Lee stated that the call for a universal, standard assessment would help assessors customize the assessment to the person being assessed to ensure that the assessment limits do not become the reason

someone who needs care does not qualify for care. Commissioner Lee stated that currently, the assessment tool is not customizable, and service needs get missed.

In response to questions from Senator Carroll, Commissioner Lee stated that EPSDT rates are negotiated with managed care organizations (MCO) based on CMS rates. Commissioner Lee stated that the significant profit margins for EPSDT service providers and the reality that many waiver program providers find that one wavier service carries the financial burden of other not-so-profitable programs needs to be addressed, and solutions that benefit both provider and participant must be found.

Medicaid Reimbursement to Rural Health Clinics and Federally Qualified Health Centers

John Inman, Chief Policy Officer, Kentucky Primary Care Association (KPCA), stated that since 1989 federal law has required Medicaid to pay federally qualified health centers (FQHC) one hundred percent of its reasonable costs related to treating Medicaid beneficiaries to prevent Public Health Service Act section 330, grant money, from being diverted from caring for individuals with no insurance and no means of paying for services. Medicaid payment for services was typically around seventy percent of costs incurred by the centers for treating Medicaid patients, and centers would cost settle at the end of each year for payment. Mr. Inman stated that in 2000, the passage of Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement Protection Act (BIPA) created the current Prospective Payment System (PPS), which was designed to reimburse FQHCs and rural health clinics (RHC), on a per-visit basis, the cost of treating Medicaid beneficiaries.

Teresa Cooper, Director of Government Affairs, Kentucky Primary Care Association, stated that in a managed care environment, the Medicaid agency still bears the responsibility of paying clinics and health centers the full PPS rate, and the MCO is required to pay the clinic and health centers no less than they would any other provider for the same services on the fee schedule. The state is required to make a wrap-around or supplemental payment to the clinic if the fee schedule payment from the MCO is less than the clinic's PPS rate. The law also requires this full payment to be made by Medicaid to the clinics and health centers no less than every four months.

Mr. Inman stated that the current payment process begins with the FQHC/RHC billing a visit to the MCO, the MCO pays the claim per the Medicaid fee schedule, the MCO submits the encounter to DMS, the encounter must cross the threshold editing DMS has in place, and if it fails any of these edits, it is rejected and sent back to the MCO. Mr. Inman stated if the claim fails, the clinics are not notified by the MCOs or DMS that it has failed the DMS editing process, and it was returned. DMS only maintains reports of these returned encounters for a short time, and they are not monitored by DMS for resubmission by the MCO. Only encounters paid by the MCO that make it across the threshold are paid the supplemental payment by DMS and that this has caused substantial losses to our clinics

dating back to 2014 because only one set of data exists to compare the claims. Ms. Cooper stated that most stated have two sets of data to compare the claims submitted and claims paid to ensure compliance with the federal law full payment requirement. Mr. Inman stated that KPCA has done extensive research and retained outside legal counsel to provide DMS with reconciliation methodologies from different states for their review and consideration. KPCA is asking to work with DMS to develop a system that would reconcile the claims submitted by clinics to MCOs and DMS's supplemental payment to the clinics, including utilizing a centralized data system being built by KPCA.

In response to questions and comments from Senator Meredith, Mr. Inman stated that the Texas model in rebuttal to PPS is regardless of the billed amount, reimbursement shall be the maximum allowable reimbursement (MAR) amount, and therefore the providers are not left in at a deficit while DMS and the MCOs figure out who pays first. Mr. Inman stated that there is a claim black hole due to the PPS plan's dysfunction and that FQHCs in Kentucky have $6 million in unreimbursed claims.

In response to questions from Representative Prunty, Mr. Inman stated that federal law states that if an MCO pays the PPS rate as an alternative payment methodology, DMS must make up the difference, yet currently, both DMS and MCOs are claiming that one cannot pay because the other has not paid yet or the reimbursement rate they are using is based on the wrong initial billing rate. Mr. Inman stated that he believes both the MCOs and DMS are in violation of federal law, and KPCA has retained counsel.

In response to comments from Senator Meredith, Commissioner Lee stated that DMS is in full compliance with CMS and federal law.

Adjournment

There being no further business, the meeting was adjourned at 4:50 pm.