

CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

* * * * *

July 23, 2015
10:00 A.M.
Capitol Annex, Room 125
Frankfort, Kentucky

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MEETING

APPEARANCES

Dr. Elizabeth Partin
CHAIR

Dr. Donald Neel
VICE CHAIR

Karen Angelucci
Sharon Branham
Peggy Roark
Susanne Watkins
Charlotte Whittaker
Eric Wright
COUNCIL MEMBERS PRESENT

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1 DR. PARTIN: I'm going to go ahead and
2 get started. We're expecting a couple other members, but
3 they're not here yet, but we'll go ahead and start
4 anyways. So, first of all, we have some new members; and
5 I'd like to welcome them. Charlotte Whittaker, here on my
6 left; and Eric Wright, welcome.

7 MR. WRIGHT: Thank you.

8 DR. PARTIN: And, then, two
9 reappointees. I have been reappointed, and Peggy Roark
10 has been reappointed. And speak of the devil, here she
11 is. So, we welcome them to the Committee. We're glad to
12 have their addition as we've been missing some members.
13 So, we're really pleased about the appointments.

14 I don't think we have a quorum yet, do
15 we?

16 DR. NEEL: How many do we need now?

17 DR. PARTIN: Nine.

18 DR. NEEL: We can't approve the
19 minutes.

20 DR. PARTIN: We've got eight, but we
21 are expecting some others. So, we may go back to that
22 later. So, under Old Business, the first item is Refund
23 requests from MCOs. And what this has to do with is the
24 providers are checking eligibility for patients when they
25 see them; and the patient is noted as eligible; and, so,

1 the patient is seen. And, then, sometime in the future,
2 after the patient visit, the patients are retro-
3 disenrolled from Medicaid. And, now, the MCOs -- in
4 particular, the one I know about is Anthem -- are
5 requesting refunds from the providers. Now, the providers
6 are seeing these patients in good faith. They're doing
7 what they're supposed to do by checking the eligibility.

8 And on further investigation, what we
9 found was -- let me find my paper here -- that this
10 request is not coming directly from Anthem. It's coming
11 through Amerigroup, which is a recovery specialist for
12 Anthem.

13 And the worker there -- in fact, I received
14 one of these refund requests; and that's how I came to
15 know about it. On further investigation, we found out
16 that Anthem has submitted over 1,000 claims from Kentucky
17 for these refund requests for these retro-disenrollments
18 of patients. And, so, they've even given us a special
19 name because there's so many of these from Kentucky at
20 Amerigroup.

21 So, I think this is a pretty
22 significant problem; and it's affecting a lot of people.
23 I don't think it's fair to the providers when the
24 providers are doing what they're supposed to do to check
25 eligibility and that there needs to be something worked

1 out, I believe, between the MCOs and Medicaid to prevent
2 this from happening in the first place. And, then,
3 secondly, for either the MCO or for Medicaid to deal with
4 the cost of the visit because I don't think that the
5 providers should be shouldering that cost. Are you
6 wanting to speak to that, Commissioner?

7 COMMISSIONER LEE: Yes.

8 DR. NEEL: Before she speaks to it,
9 I'd just like to expand on that a little. I've had
10 several in my office. And the problem, Lisa, is that they
11 were seen more than a year ago. Okay? We checked their
12 eligibility at the time they were seen; very similar to
13 what she's saying. And, so, the MCOs had hired a company
14 to drill down into this and find the claims. And usually
15 people were eligible but were maybe in the wrong company
16 or something. The problem that comes up for us is we
17 cannot resubmit a claim because it's older than a year.
18 So, that's part of what we wanted you to speak to.

19 COMMISSIONER LEE: So, I'd just like
20 to discuss a little bit about the process. But, first of
21 all, welcome to the new members and congratulations to
22 those that have been reappointed. I think we've got a
23 pretty good MAC here, and we want to keep going forward
24 with making positive policy changes. Appreciate
25 everything you've been doing and looking forward to

1 working with you and particularly those of you that have
2 just been appointed.

3 But the process for recoupments, I
4 understand how much of a headache and a hassle it is for
5 the providers; but Medicaid in the position of having to
6 maintain accurate records. And sometimes, because of the
7 new eligibility enrollment systems that we have --
8 sometimes one system -- because we have several that talk
9 to each other -- sometimes one system may have an
10 individual with a number and the Medicaid system will have
11 the same individual with a different number. And when we
12 merge those two, if they've had two different managed care
13 organizations, we have to respect the needs and the wants
14 of the member. And if they have selected an MCO, that's
15 the one that will be overridden.

16 So, sometimes that does happen. And
17 when it happens, the Department does recoup money from the
18 managed care organizations. We take back the capitation
19 payment for any member who has been reassigned, even
20 retroactively. So, in turn, those MCOs will go and recoup
21 from the providers. We understand how much of an issue it
22 is. We're trying to get those systems synced up so that
23 those eligibility -- there's no retro-eligibility
24 overwritten of the MCOs.

25 In the new contracts, we have inserted

1 some language -- the new contracts for the MCOs beginning
2 July 1st of 2015 -- we have inserted language that in
3 those events, in the event of a retroactive eligibility or
4 change in MCO, that the new MCO cannot require prior
5 authorization for any service that needed a prior
6 authorization. So, that's one step to help.

7 For those that are over a year old,
8 Dr. Neel, if you give us examples, we'll work to find out
9 what we can do to help facilitate the processing of those
10 claims because it would depend on when those claims would
11 hit the system and when everybody became aware of it;
12 because, as you've pointed out, you only have a year to
13 bill. And if it's over a year in the past, we need to
14 know exactly when that hit the system and when everybody
15 is aware of it so we can work with it. But I think that
16 the big step that we took in the new contract with the
17 prior authorization and not requiring that will help
18 alleviate some of the issues but not all of them right
19 now, but we'll continue to work forward.

20 DR. PARTIN: Okay, thank you. Will
21 you update us on that?

22 COMMISSIONER LEE: Yes; yes, we will.
23 I guess along those lines while we're talking about
24 recoupments and accurate records and things like that, you
25 may have noticed in some of the newspapers that even

1 fee-for-service has been recouping some funds from
2 providers. We've conducted some audits. Particularly, we
3 did one entire provider type. A third of those providers
4 had no errors at all and were not recouped any funds.
5 Another third of them had, I think, less than 1,000 or
6 10,000 dollars in audit findings that they had to repay;
7 and most of those have repaid. Some are in a different
8 appeal process.

9 So, anytime the Department does recoup
10 funds or we conduct an audit and we find that there may be
11 information that's missing to support the delivery of
12 services, all providers always have the option of filing
13 an appeal or providing us with additional information. We
14 can go through a Dispute Resolution Meeting that attorneys
15 are not necessary. We can sit at the table and talk. And
16 a lot of times we do that and providers can support some
17 of the documentation.

18 But our whole goal in the Department
19 -- as you know, we serve 1.2 million people now. We have
20 1.2 million members, and we have a \$9 billion budget. And
21 our whole goal is to make sure that we can support to CMS
22 -- because they provide 70% of our funds -- we want to be
23 able to support to them that we're running this program
24 appropriately. Otherwise, they'll recoup funds from us.

25 And we also want to make sure that

1 this program is sustainable going forward. We have lots
2 and lots of wonderful providers delivering services, and
3 they care so much about our members. And we want to keep
4 those providers. We want to make sure that anything that
5 we find that we can educate or any funds that are being
6 paid inappropriately are recouped; and, then, we continue
7 to educate to make sure that we can account for every
8 single dollar that is spent in this program.

9 DR. PARTIN: Thank you. The next item
10 on the Agenda is the limitation on the Level 4 and 5
11 visits. And I know this sounds like a broken record, but
12 I think that we will probably keep on bringing it up until
13 we get some resolution. I think it's becoming more of an
14 issue because of moving to payment for -- help me, what am
15 I trying to say? For ---

16 DR. NEEL: Are you talking about
17 school physicals ---

18 DR. PARTIN: No, I'm talking about the
19 Level 4 and 5 visits.

20 COMMISSIONER LEE: The more complex
21 individuals?

22 DR. NEEL: The more complex?

23 DR. PARTIN: Yes, more complex
24 individuals. And, also, we're being judged on the quality
25 of care we provide. And, so, when we document, in order

1 to meet the requirements for when we get audited to
2 providing the appropriate care for these individuals, it
3 comes up to a Level 4 on many patients. But we're forced
4 to down-code, which we're not supposed to do, but that's
5 what we do.

6 COMMISSIONER LEE: So, the Department
7 has heard you. We do listen. We have conducted research,
8 and we found in our State Plan Amendment some very good
9 news. We found in our State Plan Amendment that the
10 language actually says that it's limited, I think, to two
11 per member, per provider, per year. However, that per
12 provider seems to have been left out of our regulation.
13 And that regulation has been open twice in the past year.
14 And in the public comment period, we haven't seen that.
15 So, it was, again, overlooked.

16 But I would like to state publicly
17 that since our State Plan limits to two per member, per
18 physician, per year that the MCOs can provide two per
19 member, per provider, per year and the Department will
20 view those encounter claims as valid. So, I think that's
21 a step until we can get that regulation changed to two per
22 provider, per member, per year.

23 DR. PARTIN: And I think that that's a
24 step in the right direction, but I don't think that that
25 actually covers the problem. We're forced to do

1 inaccurate coding; and, so, the documentation for the
2 visit doesn't fit with the coding. And I think I'm not
3 unusual for providers in Kentucky, but it's not unusual to
4 see a patient who has diabetes and heart disease and COPD
5 all in one visit, and that's a Level 4 visit.

6 COMMISSIONER LEE: And in those cases
7 when you have those high complex needs, I would just
8 encourage you to reach out to the managed care
9 organizations to see if they have case managers and maybe
10 discuss those specific situations with the MCOs to see if
11 there's something that they can do to work with you to
12 make sure that what you're performing -- the codes that
13 you're performing are consistent with what you're billing
14 and getting paid for. But I would reach out to the MCOs
15 with any case specifics or to the Department for
16 fee-for-service.

17 DR. PARTIN: You know, the case
18 managers can help the patient manage their disease
19 processes; but it still doesn't help us with our
20 reimbursement. You have a patient like that, that's not a
21 ten-minute visit or a 15-minute visit. And those are
22 patients that I see everyday; multiple patients like that.
23 And it's not that their blood pressure is uncontrolled or
24 their diabetes is necessary uncontrolled, although
25 sometimes it is; but if you're managing three chronic

1 problems, that's a Level 4.

2 COMMISSIONER LEE: I would just
3 encourage you to reach out to the managed care
4 organizations for those particular clients and see if
5 there's something that they can do. Our regulation and
6 our State Plan -- our State Plan does say two visits per
7 member, per provider, per year; and that's what will be
8 reflected in the regulation when it's open. And until
9 that -- and that's the limitation. So, again, I'd just
10 work with the MCOs to see what they can do.

11 DR. PARTIN: To do?

12 DR. NEEL: In ancient history, the
13 coding was based upon time spent with the patient; and
14 that goes way, way back. And now it's based upon
15 complexity of the visit. And, so, most sick visits now
16 may be 213s; but there are many of them -- maybe 35 or 40%
17 -- that should be 99214s; and that's proper coding. I
18 guess that this limitation was really based upon financing
19 in the beginning, was it not? The limitation of the two,
20 do you know if it was based upon simply amount of funds to
21 pay? Is that why it was limited? I don't remember why it
22 was put in there in the first place.

23 COMMISSIONER LEE: I can't recall, and
24 I don't know. I wasn't here when the first ---

25 DR. NEEL: Okay, yeah.

1 How does it impact the member; how does it impact the
2 provider; how does it impact the MCOs and the contracts
3 that we have with the MCOs; how does it impact our system;
4 and how does it impact the budget. So, all of those
5 things would be looked at.

6 DR. NEEL: Okay.

7 COMMISSIONER LEE: So, if you want to
8 make that a formal recommendation so that we could look;
9 but we would have to look at that and see. And in the
10 event that it was financial, like you alluded to, Dr.
11 Neel, if there was some financial impact, we would have to
12 make sure that there was some more money put into
13 Medicaid's budget in the next Legislative Session that's
14 upcoming.

15 DR. NEEL: Because the MCOs are paying
16 it in other states. I know that.

17 DR. PARTIN: Kentucky is -- the
18 American Association of Nurse Practitioners looked into
19 it. And as far as they can determine, Kentucky is the
20 only state that does this.

21 COMMISSIONER LEE: We'll be more than
22 happy to continue the discussion ---

23 DR. NEEL: So, if we make it a
24 recommendation, then, that will have to go into the next
25 time you open up the Plan, is that what you're telling us?

1 COMMISSIONER LEE: The regulation.

2 DR. NEEL: Regulations, okay.

3 COMMISSIONER LEE: And, plus, we'd

4 have to look at the financial impact of it. Again, ---

5 DR. NEEL: Sure, I understand.

6 COMMISSIONER LEE: Because we would --

7 and, again, the Legislators will be in town this January.

8 So, Medicaid would need more money in the budget to

9 accommodate.

10 DR. PARTIN: We do have a quorum right

11 now. So, I'd like to make that recommendation.

12 DR. NEEL: Did Chris make it? Yeah,

13 there he is. Good.

14 MR. CARLE: Better late than never.

15 DR. PARTIN: That's right.

16 MS. BRANHAM: Perfect timing.

17 DR. PARTIN: So, is that sufficient

18 information for you for us to bring that recommendation

19 forward, or do you want us to write something?

20 COMMISSIONER LEE: Yes, put it in

21 writing, please, with the recommendations that come to the

22 Cabinet.

23 DR. PARTIN: Okay, we'll do that.

24 Thank you. Okay. The next item on the Agenda is the

25 Medicaid MCO contracts. And we haven't seen the

1 contracts, but we have seen the news piece that came out
2 about the contracts. So, we have questions about that.

3 MS. EPPERSON: And, Beth, if I can
4 interrupt for a second, they are in the Miscellaneous
5 section. I did provide those in your binder.

6 DR. PARTIN: Thank you. So, we got
7 those today; and we'll be looking at those. But I guess I
8 had some questions, and I thought maybe that you might be
9 able to explain some of the things. In this news article
10 in the third bullet down, it talks about 82 to 87% of
11 member capitation payments to the MCOs must be expended
12 for direct services to Medicaid members. And, so, we were
13 wondering direct services -- what that means.

14 COMMISSIONER LEE: What that means,
15 medical services provided to the members. So, for
16 example, we're holding the managed care organizations to a
17 medical loss ratio. That means that the percent of funds
18 outlined in their contract have to be spent on the direct
19 provision of services.

20 DR. PARTIN: So, is that ---

21 COMMISSIONER LEE: That would be
22 encounter claims coming through the system, medical
23 services.

24 DR. PARTIN: So, tests and visits to
25 providers and that sort of thing?

1 COMMISSIONER LEE: Anything that's a
2 valid medical claim that hits our system, yes.

3 DR. PARTIN: Okay.

4 DR. NEEL: But do services to members
5 also mean the things that the MCOs do to increase the
6 HEDIS measures or to look at quality? Is that services to
7 members, too? So, does that go into the -- in other
8 words, this is not necessarily services from providers at
9 82 to 85? I'm concerned that it means a different thing
10 to me.

11 MR. WISE: You're right. There is a
12 part in the formula called -- I think it's quality
13 initiatives that benefit the member. So, expenses that
14 the MCO has on those quality initiatives can count as a
15 benefit to the member, but the key is is a benefit to the
16 member helping improve the member somehow. We put this in
17 -- most of it this year. We followed what the Medicare
18 Program has to do, and we followed what commercial plans
19 have to do under the Affordable Care Act.

20 And the new Medicaid regulations that
21 are proposed that just came out last month will be doing
22 the same in the future for the Medicaid Program. We
23 actually put that requirement in a year or before we
24 actually had to per the Federal rules. But, yes, it's
25 benefits to the member. It has to be 85% or there is an

1 amount that comes back to Medicaid.

2 DR. NEEL: Okay, all right. It means
3 something kind of different, all right.

4 MR. WISE: There's extensive Federal
5 regulations on exactly what that means. And it's hard to
6 quote all those to you.

7 DR. NEEL: Because it sounds really
8 good when we look at it; that more is going to come back
9 to providers and members. But it's not exactly that way,
10 okay.

11 MR. WISE: It should help, but ---

12 DR. NEEL: Yeah, right, okay.

13 DR. PARTIN: And, then, the next item,
14 an incentive pool for the MCOs to improve health outcomes.
15 What is that?

16 MR. WISE: That is -- there's two ways
17 that the MCOs can earn incentives. It is based on HEDIS
18 measures. So, half of the pool we've established looks at
19 the MCO improving year over year. In other words, their
20 results from this year are better than last year. They
21 qualify for shares of the pool if they meet that on a
22 HEDIS measure. The other half of the pool is how our MCOs
23 stack up to national benchmarks. So, in a nutshell, if
24 they're over the average national benchmark HEDIS measure
25 for this statistic, then, they qualify for a share of the

1 pool. It's a 1% share of the pool basically based on 1%
2 of MCO premium. And we'll start looking at that next year
3 based on this year's results.

4 DR. NEEL: Does any of that trickle
5 down to the providers?

6 MR. WISE: It could because ---

7 DR. NEEL: It could, okay.

8 MR. WISE: And I guess we would hope
9 it would trickle down. The member primarily ---

10 DR. NEEL: Yeah, I know.

11 MR. WISE: --- is the focus there.

12 DR. NEEL: I understand.

13 MR. WISE: Improved HEDIS measures,
14 improved care for the member results in the MCO qualifying
15 for incentives.

16 DR. NEEL: Because it's important for
17 you all to understand that the HEDIS measures they're
18 working on now and the quality issues are based upon
19 claims data. And we're still finding that those claims
20 data really need to be cleaned up because right now we're
21 seeing some of the numbers we're getting just don't make
22 sense because I sit on one of the Quality Committees and
23 it's obvious they need to clean up the data. So, I guess
24 you all are looking at that, too, because you all are
25 pushing them to do the HEDIS measures to improve quality;

1 and I understand. But we've got to be sure that the
2 claims data it's based on is good.

3 MR. WISE: Sure.

4 DR. PARTIN: Okay. Then, requiring
5 national standards designated by the Cabinet to determine
6 medical necessity. What are the national standards?

7 COMMISSIONER LEE: In the new
8 contract, we have inserted that the MCOs must use Milliman
9 or InterQual for medical services. There are different
10 criteria for behavioral health services, depending on age
11 and various factors of the individual being served. But,
12 basically, all MCOs have to use Milliman or InterQual.

13 DR. PARTIN: Is that M-i-l-l-i-u-m?

14 COMMISSIONER LEE: M-i-l-l-i---

15 DR. PARTIN: i-m?

16 COMMISSIONER LEE: --- m-a-n,

17 Milliman.

18 DR. PARTIN: And what's the other one?

19 COMMISSIONER LEE: InterQual.

20 DR. PARTIN: I-n-t-e-r-Q---

21 COMMISSIONER LEE: Q-u-a-l.

22 DR. PARTIN: --- u-a-l? Okay.

23 DR. NEEL: We have no problem with the
24 use of the national standards, but how does that translate
25 into medical necessity? Is that going to be retroactively

1 determined, or is that going to be prospectively? How is
2 that going to happen? Because part of the problem we get
3 into are these retrospective things.

4 COMMISSIONER LEE: So, the contract
5 does state that for any individual who is retroactively
6 eligible and a service has already been rendered, the MCO
7 cannot require a prior authorization. So, the medical
8 necessity criteria is used to determine anytime a prior
9 authorization is requested to make sure that that service
10 meets the medical necessity.

11 DR. NEEL: Okay.

12 DR. PARTIN: Another bullet talked
13 about expanding performance requirements for Medicaid
14 members' pharmacy benefits. What does that mean?

15 COMMISSIONER LEE: I'm not sure what
16 that one is. Which section is that?

17 DR. PARTIN: It's the eighth bullet.

18 DR. NEEL: At the eighth bullet point.

19 COMMISSIONER LEE: I'm sorry. I'll
20 have to go back and research that one to find out what it
21 is.

22 DR. PARTIN: Okay.

23 DR. NEEL: I think it's looking at
24 their benefit programs to look at the performance of the
25 benefit programs is the way I read it. Can anybody else

1 expand on that? I know Jonathan could expand on it if he
2 was here.

3 COMMISSIONER LEE: We'll follow up.

4 DR. PARTIN: Okay.

5 DR. NEEL: Okay.

6 COMMISSIONER LEE: We'll look at that
7 and follow up with you.

8 DR. PARTIN: And, then, using
9 nationally-accepted, uniform standards for credentialing.
10 What are these standards?

11 COMMISSIONER LEE: It's NCQA
12 standards.

13 DR. NEEL: Credentialing continues to
14 be a problem. The length of time getting people
15 credentialed is still a real problem for providers. We
16 have people who are being six months out there getting
17 credentialed. Lee Guise, she's hiding. Where are you
18 back there? I know you're there. Once it gets to
19 Medicaid, then, it happens very quickly; and I think
20 that's not the problem. The problem is getting through
21 the MCO process. And we have wanted that to be a uniform
22 process. And that's why we're wondering how -- does that
23 mean anything as far as uniformity is concerned?

24 COMMISSIONER LEE: Well, the MCOs have
25 to follow NCQA guidelines. And that's National Committee

1 for Quality Assurance Standards. They have to meet those
2 standards. The new contract does state the time amount
3 specified that the MCOs have to credential those
4 providers, and I believe it's 90 days. Ninety days from
5 the time that they get all of the complete and accurate
6 information, they do have to ---

7 MS. BRANHAM: That's the key, isn't
8 it?

9 COMMISSIONER LEE: Complete and
10 accurate information is the key. And the Department does
11 monitor reports to see how many providers fall outside of
12 that 90 days. The MCOs do have to report that to us. And
13 what we have encouraged providers to do, if they are
14 seeing that it is taking quite a lengthy time, you're more
15 than welcome to contact the Department with any of the
16 specifics so that we can kind of help see what's going on.
17 But most often it's that there's a certain relevant piece
18 of information that's been omitted or missing from the
19 application packet.

20 DR. NEEL: Well, the MCOs are telling
21 me that they're trying to cut it to 60 days and trying to
22 keep it as close as they can to that, and I understand.
23 But part of the problem is they're not getting back to the
24 person who's trying to be credentialed quick enough to
25 find out if there's a piece of missing information. I

1 think that's part of the problem is a lot of this is --
2 don't you think so?

3 MS. BRANHAM: Yes, it is.

4 DR. NEEL: Yeah.

5 MS. BRANHAM: The length of time it
6 lands somewhere and it's reviewed to ask for additional
7 data, that's the breakdown on providers getting into the
8 service record.

9 DR. NEEL: And this is a significant
10 drag on provider reimbursement. And that's something
11 we're going to continue to work on.

12 MS. BRANHAM: Right. I see lots of
13 folks from the TACs out there shaking their head as this
14 is a problem, and maybe they can speak to that today so
15 that we'll know how many are -- what kind of groups we've
16 got are outlying there as we're trying to get folks into
17 the provider base.

18 DR. WATKINS: We have brought this up
19 at our TAC meeting, too. And they did warn us that any
20 number that was issued is not retroactive. So, if you've
21 applied for a number, to make sure that that provider is
22 not seeing patients yet until that they know that they
23 have already received their provider number or
24 authorization ---

25 MS. BRANHAM: You can't bill for

1 services until you ---

2 DR. WATKINS: Right, right. You have
3 to already be linked to that particular MCO.

4 DR. PARTIN: So, they're not doing any
5 retroactives?

6 DR. WATKINS: No.

7 DR. PARTIN: Because they used to be
8 ---

9 DR. NEEL: No, I don't think that's
10 true.

11 COMMISSIONER LEE: I think that some
12 of them are. We'll have to double-check with all of them.

13 DR. WATKINS: We were told no.

14 COMMISSIONER LEE: By all MCOs?

15 DR. WATKINS: Yes.

16 DR. NEEL: Well, that's not the
17 information that I -- we're saying they're going to be
18 paid for seeing patients. They'd almost have to be. But
19 the question is the length of time. So, will you look
20 into that?

21 COMMISSIONER LEE: Yes. And in the
22 meantime, ---

23 MS. BRANHAM: You can't bill without
24 your provider number, so ---

25 DR. NEEL: No, you can't bill until

1 then.

2 DR. PARTIN: But you can bill
3 retroactively. But it's been awhile since I was
4 credentialed. But when I was credentialed, they didn't go
5 back the full time; but I think it went back -- I don't
6 know -- three months or something. But it took me almost
7 six months, and I didn't have errors. It took that long.
8 But, anyways, that's another story.

9 COMMISSIONER LEE: So, we'll look into
10 that and find out which ones do and do not do retroactive
11 billing.

12 DR. NEEL: All right.

13 DR. PARTIN: And, then, strengthening
14 requirements for provision of behavioral health services.
15 What does that mean?

16 COMMISSIONER LEE: So, we have
17 required the MCOs to enroll at least 500 behavioral health
18 providers in their network. They also have to have --
19 just one moment; let me find the behavioral health
20 network. I know they have to have at least 500. They're
21 required to have at least 50% of the behavioral health
22 providers that the Department has enrolled in their
23 network in each region. And they also are required to
24 have no less than 500 behavioral health providers in their
25 network in total.

1 DR. PARTIN: What type of mental
2 health providers are we talking about?

3 COMMISSIONER LEE: We would be talking
4 about, of course, the Community Mental Health Centers, but
5 any other provider type enrolled in Medicaid to deliver
6 behavioral health services such as psychologists, licensed
7 marriage/family therapists, LCSWs, licensed clinical
8 social workers and associates and those sorts of
9 providers.

10 DR. PARTIN: So, that's all included
11 in that 500 number?

12 COMMISSIONER LEE: Yes.

13 DR. NEEL: I'm sure Sheila will speak
14 to that later, but you just can't invent these people.
15 Our problem in our community is they just don't exist.
16 It's wonderful that now you're going to pay them, but it's
17 just going to take some time to get that going. As I
18 said, I'm sure Sheila -- you're going to speak to that,
19 aren't you?

20 DR. SCHUSTER: I'm sure I will.

21 DR. NEEL: Okay, thanks.

22 DR. PARTIN: Those were the only
23 questions I have, but what about other members of the
24 panel. Do you have questions about the contracts?

25 MS. BRANHAM: Not really.

1 DR. PARTIN: And, Peggy and Chris,
2 Barbara put the contracts in our binders. So, we'll have
3 those to look at. Okay.

4 MR. CARLE: Thank you.

5 MR. WRIGHT: Might I ask a question?
6 I just want to clarify, too, for Medical Assistance
7 recipients, particularly those with intellectual and
8 developmental disabilities, they're not falling in MCO
9 contracts currently. Are they receiving services within
10 MCOs? No. Correct me if I'm wrong.

11 COMMISSIONER LEE: If they're in a
12 Waiver, if you're talking about ---

13 MR. WRIGHT: Right, Waiver recipients.

14 COMMISSIONER LEE: --- individuals in
15 our Waivers.

16 MR. WRIGHT: They're outside.

17 COMMISSIONER LEE: They are outside.
18 They are carved out of the managed care organizations.

19 MR. WRIGHT: Thank you.

20 DR. PARTIN: So, moving right along.
21 At the last meeting, a comment was made regarding coding
22 for smoking cessation. And it said if the -- the person
23 said if the provider enters the CPT code for smoking
24 cessation plus an E/M code, that the MCOs aren't paying
25 for the visit; and I wanted clarification on that.

1 COMMISSIONER LEE: Yes, we did receive
2 information from each MCO on this issue. And there in the
3 very last page of your binder is a summary of all of the
4 MCOs and the coverage of the smoking cessation.

5 DR. NEEL: All right, thanks.

6 DR. PARTIN: So, you can put in the
7 CPT code for the smoking cessation and use an E/M code for
8 the visit?

9 COMMISSIONER LEE: It depends on the
10 MCO. So, the very last page, we have all five MCOs and
11 their policy on those smoking cessation.

12 DR. PARTIN: Okay.

13 DR. NEEL: Thank you.

14 DR. PARTIN: So, I'm going to jump
15 back up to approval of the minutes as we now have a quorum
16 and ask for a motion to approve the minutes.

17 MS. BRANHAM: I'll make a motion.

18 DR. NEEL: Second.

19 DR. PARTIN: Any discussion? All in
20 favor say aye. Opposed. So moved. Thank you. And,
21 then, this isn't on the Agenda because I received the
22 request after the Agenda was written, but Peggy Roark had
23 a question about rehab.

24 MS. ROARK: Well, I have several
25 questions, but I can't get them addressed. But maybe

1 after the meeting, I can speak to MCOs. My big question
2 is my daughter has been in three rehabs, and she was
3 currently in Recovery Works. And she's got Humana, and
4 they would only pay for 20 days, and she needed more than
5 that. So, I'm trying to find out the big question with
6 all MCOs; how much are they paying for the rehabs. And I
7 need a list of what they're paying to help all of us
8 parents out here that's struggling and trying to help our
9 children get into rehabs.

10 DR. NEEL: Do you mean how much in
11 dollars or how much in periods of time?

12 MS. ROARK: Time. What do they pay.

13 DR. PARTIN: What are they allowing
14 for the time ---

15 MS. ROARK: Yes.

16 DR. PARTIN: --- for the rehab.

17 DR. NEEL: What they're allowing; not
18 so much what they're paying but what they're allowing.

19 MS. ROARK: Yes.

20 DR. NEEL: Paying for.

21 COMMISSIONER LEE: We believe that all
22 therapy should be individualized for each person based on
23 their needs. If you want to talk to the specific MCOs
24 after this, I think that may be a good idea for you;
25 particularly the one that your daughter is enrolled with.

1 But they do have to provide the services outlined in our
2 regulations. They have to cover all services, and they
3 have to meet medical necessity. So, I would just
4 encourage you to talk to them afterwards.

5 MS. ROARK: She's been in three
6 rehabs. She was in Cumberland Hope, and they was a very
7 good one, but she left. And they was willing to help her
8 get mental health, help her with -- she has a heart
9 condition and other health concerns. She went into
10 Healing Place; and they told her if you've got a heart
11 condition, you've got mental health, you need to go on and
12 get that fixed; and, then, you can come back and work on
13 your addiction.

14 I did not agree with that. And it was
15 hard to get them back on the phones. And, then, Recovery
16 Works, that's like 20 days. And I don't know. I'm just
17 -- it's funny how each one of them has all these different
18 rules. And she's had Humana with all three of those. But
19 it's a lot of questions, and I'll talk after the meeting.

20 COMMISSIONER LEE: And I'll be more
21 than happy to talk with you after the meeting, too, to see
22 if there's anything the Department could do. But I do --
23 you know, we need to pull in the managed care organization
24 and see what other services may be available and things
25 like that.

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MS. ROARK: Okay, thank you.

DR. PARTIN: Then, next on the Agenda is Updates from the Commissioner.

COMMISSIONER LEE: We've talked a little bit about the managed care contracts. You know, that effective July 1st, we have new contracts for the MCOs. We still have five MCOs, no more. I was at a meeting earlier this week in which a state was talking about having 19 MCOs. So, I felt very fortunate in Kentucky at that point. We do have one contract for all of the MCOs. You do have a copy of that in your binder. They all participate statewide now. Every single MCO can serve members in every region.

We are working on one common prior authorization form and one appeal form for members and providers to use. We have stated in the contracts that MCOs have to update their online provider networks within ten days of a change. We do have language -- we have beefed up our language regarding the MCOs being more involved when individuals with severe mental illness are being discharged from mental hospitals. There's language in the contract that makes the MCOs -- they have to be more aggressive about involving those individuals in care and finding care after they are discharged.

We've tightened up the penalties

1 section a little bit for the encountered claims that come
2 into the system. We have made some improvements to fraud
3 recovery requirements. So, for example, if the Department
4 or maybe the Federal Government finds fraud and abuse that
5 the MCO has not found, if we find that before the MCOs
6 have reported it to us, the state will be able to keep
7 those funds rather than the MCOs being able to keep those
8 funds.

9 And, again, retroactive eligibility
10 for individuals who get retroactively enrolled in a
11 managed care organization, we have stated that the MCOs
12 cannot require a prior authorization for services that
13 would require prior authorizations.

14 Just a couple of other updates from
15 the Department. We are going to be having some forums
16 around the state, some managed care forums for providers.
17 They're going to be one-day forums. I believe the first
18 one is August 5th. The schedule is out on our website.
19 These forums are going to mirror somewhat some of our
20 previous forums, except they're going to be a little bit
21 scaled back. It's going to be one day.

22 There will be updates from the
23 Department. Behavioral Health will also be providing some
24 updates, as well as the Department for Public Health. But
25 our main focus is to have those MCOs available all day

1 long so that providers can come in and ask questions and
2 talk to them. The MCOs will not be presenting at the
3 forums as they did in the past, but they will be available
4 to address providers' questions and concerns.

5 The Centers for Medicare and Medicaid
6 Services has issued proposed managed care rules that the
7 state is looking at. And we will be submitting comments
8 by the deadline, which is July the 21st. Some of the
9 provisions in the new rules we feel like we have already
10 incorporated in our new contracts. So, we feel like we're
11 in pretty good shape.

12 We do have -- our dental reg is open
13 right now for public comment. So, I think it closes in a
14 few days. So, if anybody wants to get out and look at the
15 dental reg and make any comments. We do have 12
16 regulations that just closed that we're working on. And
17 we also have another 12 related to Waivers and some
18 changes that will be filed in the very near future.

19 Open enrollment for members to change
20 their managed care organization is October the 19th
21 through December the 11th.

22 We also will be this year mailing out
23 -- or next year -- the 1095-B's; next spring. We just
24 want to give everybody a heads up that next spring the
25 Department will be mailing out 1095-B's to Medicaid

1 recipients. This is a form that they will need to use to
2 file their income taxes so that they're not penalized. It
3 shows that they were covered by insurance so they're not
4 penalized. So, those will be next year.

5 On August the 5th -- you know, we
6 continue to make changes and amendments to our eligibility
7 and enrollment system. Beginning August the 5th for
8 individuals who are incarcerated, we will be suspending
9 their eligibility rather than terminating their
10 eligibility. That will facilitate their enrollment into
11 the program easier when maybe they're released for
12 emergency services more than 24 hours. And upon release,
13 it would be an easier -- we'd just re-enroll them or turn
14 that suspension off so that they can access their
15 medications.

16 And we do have some updates for our
17 Waiver programs. And I'd like to ask Leslie Hoffman, the
18 Director of Community Alternatives, to come up and give
19 you an update on some of our Waiver programs.

20 MS. HOFFMAN: Good morning. I'm here
21 today to talk to you about some very positive upcoming
22 events in the Waivers for providers as well as the
23 members. Our ABI Long-Term-Care Waiver, which is our
24 Acquired Brain Injury Long-Term-Care Waiver, we are
25 actually releasing 120 slots tomorrow, which is a very

1 positive thing for many, many folks. Of the 120, 68 will
2 be reserved for MFP, which is Money Follows the Person
3 demonstration grant for those folks coming out of
4 facilities -- nursing facilities and ICF/MRs -- or DDs,
5 I'm sorry.

6 Another note would be that the ABI
7 Acute Waiver has also received approval for some
8 additional slots. However, we will need to make an
9 amendment to that Waiver. So, we're currently working on
10 that now and hope to have that submitted sometime in late
11 September.

12 On another note, the Michelle P.
13 Waiver, we will be releasing 392 slots tomorrow, which,
14 again, is a very positive note for members and providers.
15 And, then, the SCL Waiver, we will be able to release 240
16 slots with the first year of the new Waiver renewal, which
17 hopefully will be sometime in September. So, those were
18 slots that were appropriated in the biennium budget; and
19 we're very excited to get those slots out to the members
20 who need them.

21 DR. PARTIN: Thank you.

22 MS. HOFFMAN: You're welcome.

23 COMMISSIONER LEE: I think that's all
24 for updates right now.

25 DR. PARTIN: I have one question.

1 COMMISSIONER LEE: Okay.

2 DR. PARTIN: Where you said about if a
3 patient is retro-enrolled in a different MCO that there
4 would be no pre-authorization, does that cover like
5 medication and stuff like that?

6 COMMISSIONER LEE: It should cover
7 everything, yes.

8 DR. PARTIN: So that the new MCO can't
9 say they can't have that medication any longer?

10 COMMISSIONER LEE: Right. And they
11 would have already had the medication if it had been
12 retroactive anyway. So, yeah, they can ---

13 DR. PARTIN: Did you hear what she's
14 saying? She's saying that it may not be on the formulary.
15 But what happens a lot when patients switch in my
16 experience is that you've got to change some of their
17 medicine or you've got a test ordered and now they can't
18 have the test until you go through the whole process
19 again. So, all that is supposed to be taken care of, is
20 that right?

21 COMMISSIONER LEE: There shouldn't be
22 any retroactive. So, for example, the member would have
23 already had the services. And in the event that one MCO
24 recoups for those services, the new MCO -- since the
25 services have already been delivered, the new MCO cannot

1 require prior authorization on anything that would have
2 been prior-authorized. I don't believe that what you're
3 speaking about with -- maybe if they move from one MCO to
4 another, the different formularies. I'm not sure that
5 that's addressed.

6 MR. WISE: Yeah. I mean, they all
7 have different procedures.

8 COMMISSIONER LEE: Right.

9 MR. WISE: And you'd have to send in
10 your letter recouping from the other MCO which establishes
11 your date.

12 DR. PARTIN: So, yeah, I'm not
13 understanding then.

14 MS. BRANHAM: So, in other words, a
15 patient is receiving x, y, z services from MCO. They have
16 decided to change their MCO provider. What they've been
17 on before, been receiving doesn't necessarily carry
18 forward with the new MCO when preauthorization is required
19 for the new MCO for services because everything -- or
20 because the authorizations are different, whether it has
21 to do with their formulary or signed orders or what. Is
22 that accurate?

23 COMMISSIONER LEE: So, if a service
24 requires a prior authorization and that member has already
25 received the service through a previous MCO, the new MCO

1 cannot require a prior authorization for that service.
2 They must ---

3 MS. BRANHAM: --- from them.

4 COMMISSIONER LEE: That they received
5 in the past. They've already received the service. A
6 member receives a service in the past, and the new MCO
7 comes in today to retroactively cover that service. If
8 that MCO -- if the new MCO requires a prior authorization
9 for that service, they cannot require it for the service
10 that was provided in the past.

11 DR. PARTIN: Okay, but not for new
12 services. So, for instance, ---

13 COMMISSIONER LEE: Right, correct.

14 DR. PARTIN: --- if a patient had an
15 MRI ordered and you went through the preauthorization
16 process and you got it approved and it was scheduled for
17 next month or something like that and, then, they have a
18 new MCO when it's time for them to have the test, you'd
19 have to go through the pre-authorization again.

20 COMMISSIONER LEE: At that point, they
21 would, if that service required a preauthorization. What
22 we were addressing with this is we heard that some
23 providers -- for example, with the retroactive changes in
24 MCO, providers were stating that they could not get a
25 prior authorization for a service that was delivered in

1 the past. Therefore, it was preventing them from billing
2 and getting paid for that service that they had already
3 delivered.

4 DR. PARTIN: Okay.

5 COMMISSIONER LEE: So, what we wanted
6 to address was that we did not want the managed care
7 organizations to deny a service that was delivered in the
8 past that they are now responsible for. Maybe they just
9 became responsible for it today. If they require a prior
10 authorization, they cannot require that prior
11 authorization on the service that was already delivered.

12 DR. PARTIN: Okay, thank you.

13 MS. WHITTAKER: I have a couple of
14 questions. On the Waiver, the Money Follows the Patient,
15 how many slots do we have statewide? I know you're
16 releasing 68.

17 COMMISSIONER LEE: Uh-huh
18 (affirmative).

19 DR. WATKINS: And how do you determine
20 who gets 68 slots?

21 MS. HOFFMAN: So, currently, right
22 now, there are slots in the ABI Long-Term-Care Waiver.
23 And we had asked originally CMS to give us a set number of
24 slots. So, we need 68 of those to be reserved for the MFP
25 members that we had already asked for approval for through

1 CMS. The current SCL Waiver also has slots, for lack of
2 better words, reserved for MFP members through the
3 emergency slots. Does that make sense?

4 MS. WHITTAKER: It does. Thank you.

5 MR. CARLE: Another follow-up question
6 with that. In consideration of these 392 spots for
7 Michelle P. Waiver and the 240, I'm seeing that that's a
8 substantial amount. I'd like to see if we can get kind of
9 a feel for where we are with the number of requests for
10 those slots, particularly for the Michelle P. Waiver,
11 looking at how many people are still waiting for services.
12 Can you speak to that, please?

13 MS. HOFFMAN: Uh-huh (affirmative).
14 Currently, right now, in the Michelle P. Waiver, we have
15 approximately 4,344 on the waiting list. I was looking
16 this morning. It appears that there's about 70% of those
17 that are children. And we have active currently right now
18 9,909, which about 50% is children, active.

19 DR. PARTIN: Any other questions?

20 DR. NEEL: Just a quick one. Without
21 getting into detail, looking into the future, newspapers
22 are already reporting that we were so successful in the
23 expansion of Medicaid that now we have many more members.
24 And, then, talking about how do we pay for those in the
25 future when we don't get 100%. And they're talking about

1 the fact that hospitals will have more insured than
2 uninsured. Will we look at decreasing disproportionate
3 share payments, will we look to adding long-term care.
4 Are you all internally -- are you looking to the future
5 there? Because that's got to be a big thing for the
6 future. Can you share some of the -- I know you all -- is
7 it true that we had more than anticipated members in the
8 expansion? They keep saying you didn't anticipate that,
9 but is that really true?

10 COMMISSIONER LEE: Yes, that is true.
11 Our projections -- you know, we first did one white paper
12 in 2013 on reasons to expand; one of those being that it
13 did have a positive impact on the state. Right now, the
14 State of Kentucky's unemployment rate is lower than the
15 national average. That is the first time in I don't know
16 how long. And while we can't attribute all of that to the
17 expansion, we do believe that it had an impact on our
18 uninsured.

19 But going forward, the State of
20 Kentucky always does their budget two years in advance;
21 and that's the amount of time that we do those budgets.
22 But I think that when we look at expansion and we look at
23 going forward, we can't just look at Medicaid as
24 expenditures and what's going on.

25 Because, for example, the Department

1 for Behavioral Health delivered a lot of services; and
2 they paid for those services with 100% State General Fund
3 dollars. When those individuals became Medicaid-eligible,
4 we're getting now 100% for those individuals -- 100%
5 Federal funds, which means that freed up just a little bit
6 of State General Fund dollars that was transferred and
7 being used for other purposes. And, also, in 2021 when we
8 begin paying our full share, it's only going to be 10%.
9 So, again, we're going to be drawing down 90% Federal
10 dollars for those services versus 100% State General Fund
11 dollars.

12 And I think that we just need to look
13 at this as a whole. And what the purpose was was to
14 insure individuals and give them access to healthcare.
15 And we do know that many of our expansion members are
16 accessing preventive services at a little bit of a higher
17 rate than some of our traditional Medicaid members. We
18 also know that our Medicaid members do have some complex
19 healthcare needs, but they're getting those treated
20 earlier rather than later. So, we have to -- I think have
21 to keep our eye on the future and what's going to happen
22 to our workforce and the health of our individuals if they
23 have access to healthcare.

24 So, I'm not sure that that answers
25 your question; but we're here for a specific purpose. And

1 that's because we had so many individuals -- almost
2 500,000 individuals in Kentucky that could not access
3 healthcare because private insurance was out of reach for
4 them. And Medicaid and the Exchange now has been their
5 safety net.

6 DR. NEEL: Thanks.

7 DR. WATKINS: I would ask, though, to
8 please -- for the MCOs to continue to outreach this
9 preventative care; because I did hear at our TAC Meeting
10 that all the MCOs were claiming that, yes, they were
11 letting their members know that they do have this
12 preventative care. But something is not going out;
13 because I had a couple come in yesterday that these were
14 normal, average, intelligent, middle-aged people. Both of
15 them telling me that they had not had a comprehensive eye
16 exam in six, seven years.

17 The wife was an insulin-dependent
18 diabetic. She had had diabetes for six years; had not had
19 an eye examination. And they were listed as being
20 self-pay. And I was telling her that -- you know, once I
21 found out that her eye pressures were high, that we were
22 going to need to be bringing her back for other testing
23 for her being a glaucoma suspect, I said, ma'am, I said,
24 you know, with you being an insulin-dependent diabetic, I
25 said, do you not have any health insurance at all? And

1 she said, well, we have Passport. That's all we've got.
2 And I said, you have Passport? That's insurance. I said,
3 you know, they'll cover your eye examination as that being
4 a medical necessity.

5 And her husband said, oh, well, I have
6 that, too. Will they not cover me even though I'm not a
7 diabetic? And I said, yes, sir, they sure will. They
8 were like, well, we need to have a celebration. I think
9 it's time for some chicken fries, you know. And these
10 people had been this long without an eye examination. So,
11 I mean, the word is not getting out.

12 COMMISSIONER LEE: I appreciate that,
13 Dr. Watkins. Thank you so much for that story. And I
14 think that it goes to show that we have 1.2 million
15 members in Kentucky on Medicaid; and we all have to do our
16 part -- the MCOs, the Department, and the providers -- in
17 educating our individuals, not just on what their benefits
18 are but how to appropriately use those benefits. So, I
19 think it's just going to take all of us to continue to
20 spread that message to all of our members. Thank you.

21 DR. PARTIN: Anything else for the
22 Commissioner? Thank you very much.

23 DR. NEEL: Thank you.

24 DR. PARTIN: The next item on the
25 Agenda is the State Innovation Model; how do we redesign

1 the model for providing services?

2 DR. LANGEFELD: Good morning. So, I
3 think you have a presentation. It's actually the first
4 page behind your Miscellaneous tab for reference. And
5 this is a follow-up, I think, to our last meeting where we
6 talked about this briefly. So, first, let me understand.
7 So, Innovation Centers, CMMI, SIM, State Innovation Model,
8 are those words familiar to anybody on the panel? A
9 little bit. Okay. So, what I want to do is just give you
10 a brief overview of what this really means and what it's
11 about and see what questions you might have.

12 The Innovation Center or what we call
13 the Center for Medicare and Medicaid Innovation was
14 actually established by Congress under provisions of the
15 ACA legislation in 2010. And it was established under the
16 Social Security Act 1115A. So, that's where it lives,
17 resides. But its intent is that it will provide both
18 funding for and technical assistance support for new,
19 innovative models of service delivery, healthcare delivery
20 and the economic model that supports it.

21 And, so, there have been a number of
22 initiatives that have been supported; some of which you
23 may be involved in. For example, you've heard of
24 Accountable Care Organizations, ACOs. The pioneer ACOs,
25 the Shared Savings Plans. There are many different models

1 that are out there that some of you may be involved in.
2 And the Comprehensive Primary Care Initiatives. There are
3 other primary care initiatives. Many of them are
4 primary-care-oriented. All of those are examples of the
5 Innovation Center providing funding and support to say
6 what works better and how do we pay for that in a
7 different way.

8 So, the State Innovation Model work is
9 actually an initiative by the Innovation Center under this
10 premise. It says: How or can state governments be an
11 accelerator of transformation in healthcare? Because they
12 can be a convener. They can be -- they can use policy
13 levers. They're a large payor in Kentucky where 25% of
14 the population plus state employees. And there are lots
15 of regulatory levers that may be able to be used to change
16 healthcare. And move it from kind of that traditional
17 state to where we are today, to where we hope to be in the
18 future.

19 So, on page 2, you see an overview of
20 that. Ultimately, what are we trying to accomplish. The
21 objective, as it always is, is what we call the Triple A.
22 We want better health for our population, improved care
23 for individuals, and what we increasingly call value or
24 financial stewardship.

25 And, so, one of the things I want to

1 be clear about is this is not a Medicaid-specific
2 initiative. It is meant to cover the full spectrum of
3 payors in the state. Obviously, in Kentucky, Medicaid is
4 a large payor. So is Medicare. But this initiative is
5 meant to involve and incorporate as key stakeholders all
6 payors so that there's -- you, as providers, understand.

7 If people come to your facility or
8 your office, you don't want to have to stop and think who
9 does this belong to, who does this person belong to. You
10 want to be able to provide care in the most effective way
11 regardless of payor. So, that's an overview of what the
12 State Innovation Model work and initiative is all about.

13 So, let's talk about kind of what that
14 is in Kentucky. On page 3, what you see is how this has
15 progressed. The initial funding for this initiative
16 occurred in 2012, and there was about \$300 million
17 allocated at that time for the first states that were
18 involved in this. The second round, which started and was
19 awarded in December of 2014, which Kentucky responded to
20 that and was awarded a grant funding for what we call
21 planning.

22 Now, what does that mean? There are
23 two different essential levels of the State Innovation
24 Model work. One is what we call design phase, meaning
25 let's get everyone together and talk about what a

1 transformation might look like and what the economic model
2 might look like that would support that best and put a
3 plan together, all collectively together. So, that's
4 design work.

5 Kentucky applied for that. The ranges
6 of awards were generally one to three million dollars.
7 Kentucky received \$2 million to support just the planning
8 phase of that. That's what we're in this year.

9 The second phase is what's called
10 testing, which means take your design and test it. Does
11 it work; does it show benefit. Now, the testing phase has
12 included funding support for states that have been awarded
13 in the range of 50 million to 100 million dollars. So, it
14 really is a way to say how can we help states and
15 providers in the states and all stakeholders get through
16 that transition and at least get started.

17 So, that's where we are. We're in the
18 Model Design Phase of the State Innovation Model
19 initiative. So, let's talk a little bit about what that
20 means and what we've done so far. Page 4 really talks
21 about some of the components that have been outlined.
22 Now, one of the advantages, I guess, of not being first is
23 that you learn from those who went ahead of you. So, some
24 of the components of the State Innovation design work that
25 have been envisioned and incorporated into some of the

1 work you see on page 4.

2 So, you know, what does a service
3 delivery transformation plan look like? How do we align
4 state and federal innovation levers and thoughts? What do
5 we do to monitor the plan? How do we align quality
6 measures? Huge issue, as we've talked about in this
7 forum. Everybody is overwhelmed with measuring quality;
8 let's move the meter. But we have to do that by aligning
9 and converging a lot of that thought.

10 What's the payment model look like?
11 How is it different than what it is today? How is more
12 effective? How do we use regulatory levers to help
13 facilitate that? What is the foundation of what's called
14 Health Information Technology infrastructure piece? And,
15 finally, you see the piece of what's called the
16 Stakeholder Engagement Plan.

17 So, all of those -- there are a lot of
18 content around that. I'll let you read through that. But
19 if you go to page 5, one of the key components that I want
20 to make sure we don't miss. When we think about health,
21 you know, a lot of people say, well, why haven't we gotten
22 the results we hoped for to-date. We've talked about the
23 fact we haven't moved the needle in Kentucky in 25 years.
24 How do we do that? What do we think about it?

25 And part of it is our thinking about

1 what health means I think is evolving. And we now are
2 increasingly recognizing that we can't just think about
3 health in a very narrow way as it relates to just doing a
4 lot of services on the back end. We have to think about
5 it in the context of health being total mental, physical
6 and social well-being in the context of the social
7 determinant.

8 So, what impact does our environment
9 play on our disparities in our socioeconomic status or
10 things that have to do with genetic factors or behaviors?
11 So, those components that we've spent less energy on, how
12 do we think about that? And that's what's called the core
13 of the State Innovation Model work as envisioned by the
14 Innovation Center. It's what's called the Population
15 Health Improvement Plan. And, so, all of those components
16 make up the Model Design as it's envisioned structurally
17 by the Innovation Center.

18 Page 6, you see our current process or
19 our current structure of work. And what we have is a
20 Multi-disciplinary Core Team made up of individuals from
21 the state. We have an External Stakeholder Group. And,
22 then, we have, as you see on the bottom, five active
23 workgroups that are involved. The workgroups have been
24 divided up to look at increased access, integrated and
25 coordinated care, quality/strategy metrics, payment reform

1 and Health Information Technology infrastructure. So,
2 that makes up the components of the active work.

3 And how this has occurred -- well,
4 I'll get to that in just a minute. Let's go to page 7 and
5 talk a little bit more also, then, about the components of
6 our Population Health Improvement Plan. One of the things
7 that's required by the Innovation Center outlined in a
8 combination of CMS and CDC is to say your Plan should at
9 least begin to address some of the issues and disparities
10 around three core areas; obesity, tobacco use and
11 diabetes. Because that tends to be a common thing across
12 most populations, and certainly in Kentucky that's true as
13 well.

14 So, as we begin to talk through the
15 workgroups, a lot of the things emerged -- a lot of
16 thought emerged about, well, wait a minute; we're already
17 beginning to address that and, in fact, it's even broader
18 in the Governor's initiative around kyhealthnow. And, so,
19 what's occurred is that's expanded from those basic three
20 to now incorporate all of the components of kyhealthnow to
21 make sure we align and harmonize at a state level a
22 Population Health Initiative effort.

23 So, the work, if you look at page 8,
24 has included all of these workgroups that have met. We
25 have met at least monthly. All of the workgroups meet

1 individually. This week has been a little bit different.
2 And, then, we have a large stakeholder meeting where
3 people come together collectively. And, so far, all of
4 those meetings have been in Frankfort.

5 And we've been very excited by the
6 fact that our activity or involvement has been from people
7 across the entire state from Paducah to Pikeville and
8 everywhere in between. And, in fact, you can see the
9 numbers of people that have been involved. Probably after
10 yesterday, probably close to 1,000 people that have been
11 actively involved in a lot of these discussions. And our
12 workgroups, you see the averages there; and I won't go
13 through them in detail.

14 But the point is that these are people
15 that represent all key stakeholder groups that we can
16 think of. Now, I'm going to come back to that in just a
17 minute; but let me move to page 9; because with this group
18 -- this work started in February of this year. And we've
19 had monthly meetings and a lot of interim smaller group
20 meetings. And taking all of that information, what has
21 been put together is what we call our straw person, sort
22 of our structural diagram of what this might look like.

23 There's a lot of detail behind it, but
24 here's in one page what the Plan looks like or what our
25 straw person looks like. And what you see is, of course,

1 as I described at the top, we have our Population Health
2 Improvement Plan initiatives, basically our kyhealthnow
3 initiatives. At the bottom, you see some emerging what
4 I'll call operational and economic models. Things like
5 patient-centered medical home that many of you may be
6 involved in; Accountable Care Organizations, health home
7 activities, bundled payments which Medicare has just come
8 out with and taken up to a different notch.

9 And the fifth area there is a
10 long-term -- a Multi-Payor Community Innovation Support
11 Center. We probably ought to think of a better name for
12 that. And here's what that means. What it means is every
13 community may have its own unique character, and they may
14 develop initiatives that don't fit easily into some
15 bucket. And, so, we wanted to allow -- or a region. It
16 doesn't have to be just an individual community. So, we
17 wanted to allow an opportunity where a community or a
18 region says we're doing this; this is working really well
19 for us. And, then, that's a model that we could support
20 and have the flexibility to support.

21 At the bottom, you see the strategies.
22 And, again, these are very high-level; but the strategies
23 that have a lot of detail behind them of looking at
24 access, HIT infrastructure, consumer strategies, quality
25 strategies, workforce strategies, and other supporting

1 strategies which incorporate a number of different things
2 like things that this Committee talks about all the time.
3 How do we create efficiencies, how do we create some
4 consistency in what our work are, and why do we have to
5 think about things different for every payor. So, that's
6 an example of things that would fall under some of the
7 other supporting strategies.

8 Now, again, a straw person by design
9 is put out to say, hey, now is the point that we want to
10 challenge this. Tell us what's wrong with this. Tell us
11 how it needs to be revised or redone or added to or
12 augmented. And, so, we've had some great meetings this
13 week. Actually, this is the week of our July meetings.
14 And, yesterday, we had a whole-day session hearing from
15 people all over the state about a lot of the initiatives
16 that they're currently actively involved in to understand
17 what's working and what are you thinking about and how can
18 we think about this as we go forward.

19 So, page 10 is really just a
20 description. This is, obviously, an iterative process.
21 There's no plan that somebody has on the shelf that we've
22 pulled off and trying to get everybody to sign off. It's
23 something where active involvement is important. And
24 before I finish up on the time line, here's, I guess, one
25 of the asks of this group.

1 When you sit down and think about who
2 all needs to be involved, if you're going to talk about
3 transformation of a system or some people would say a
4 non-system in some ways and the economic model that might
5 support that best and you want everybody involved in it
6 and you try to come up with a list of who should be
7 involved in that discussion, you're never complete. So,
8 the question or ask I have of you is who needs to be here?
9 All of you may need to be there because it's something you
10 haven't really heard a lot about, right, or your
11 organizations that you're a part of.

12 One of the things that we've been
13 reminded over and over -- where's Sheila?

14 DR. SCHUSTER: I'm back here.

15 DR. LANGEFELD: Is that we desperately
16 need what some people call consumers, some people call
17 patients, some people call persons. I call them citizens,
18 Kentucky citizens. How do we engage people to say what's
19 your problem, what's your concerns about trying to access
20 the systems, what are the hurdles for you, how can we
21 think about a system that responds to your needs? So, I'd
22 welcome comments and thoughts about what you think about.
23 And our messaging around that, right, Sheila?

24 DR. SCHUSTER: Right.

25 DR. LANGEFELD: How we talk about

1 things and how we understand the psychosocial components
2 and be sensitive to that. Our time line, as you can see,
3 is we've been actively working since February. There are
4 some deliverables where we'll send back -- we've already
5 sent back the draft of the initial Population Health
6 Improvement Plan. We're putting together some other
7 interim progress reports to CMS. As you see, the final
8 draft, we're hoping to have at least a draft of by the end
9 of the year and a final Progress Report or a final Plan by
10 January of 2016.

11 So, with that, I may have gone through
12 it too quickly, but let me know what your questions are
13 around that and/or thoughts.

14 MR. CARLE: Thank you, Dr. Langefeld.
15 I have a question. You raised a very good question to us,
16 and it kind of goes back to the scenario that was brought
17 up before that there are things covered within the state
18 that some people don't realize; and, so, it's all about
19 education. But I have to ask the question, so, we just
20 literally got a copy of the contract for the MCOs. Has
21 anybody taken the time to see how your initiatives that
22 are very aggressive match up with what's covered in the
23 new contract with the MCOs? Are these initiatives for
24 obesity, smoking cessation, tobacco use, are they covered
25 by our current Plan? And I think that's a good place to

1 start because if they don't match up, we have a problem.

2 DR. LANGEFELD: Right. Very good
3 question. I think one of the things that we've tried to
4 do is align completely or at the very least harmonize the
5 thoughts. Kyhealthnow, the Governor's initiative,
6 obviously has been in place for over a year-and-a-half
7 now. Many of the things that we're doing from the
8 standpoint of preventive strategies and how to align that
9 and support it with benefits coverage, certainly related
10 to Medicaid, have been incorporated not only into
11 contractual requirements but performance metrics relative
12 to that population.

13 MR. CARLE: Thank you.

14 DR. NEEL: We started a community
15 initiative about 15 years in my community in the Owensboro
16 area called Healthy Horizons. And we attacked smoking
17 first; and we became, I think, the third county, if you
18 would, to go non-smoking or have a smoking law. And now
19 we're looking into other things; obesity, cancer and drug
20 abuse, which is one of the things. So, I think the idea
21 of doing it community by community -- it's almost precinct
22 by precinct, if you will -- I think has some merit because
23 each community is a little different and has its own
24 things.

25 So, we've been pretty successful. And

1 we tried to involve all the stakeholders, get people who
2 were business people, government people, everybody
3 involved and not just the health people involved to make
4 it work. So, I think it can work that way.

5 DR. LANGEFELD: Well, it has to be.
6 This is a discussion that can't just reside in traditional
7 healthcare. It has to reside in communities because
8 people's concerns and needs at the community level involve
9 many more things. It includes education and housing and
10 transportation and food. All of those things are
11 critically important. It's not just the services that are
12 available or not on traditional healthcare.

13 But you're right. And that's some of
14 the things -- in fact, we heard from some folks yesterday
15 from your community and some of the things they're
16 involved in. And all of you sitting there have probably
17 been involved maybe in different initiatives. A lot of
18 the things that we're talking about are not new
19 discussions. We've been talking about them for a long
20 time.

21 I think one of the differences now is
22 hopefully we have a forum where everybody can talk about
23 it at the same time rather than in these disparate silos
24 that traditionally we've been involved in. And, so, I
25 hope that we can engender that kind of activity and

1 support.

2 And I would welcome all of you to
3 participate. There is a website; and, actually, I'll send
4 that out. I should have put it in the slides. It has all
5 the materials that have been generated so far and
6 information and when the meetings are or any information.
7 And if you have questions, you can let me know as well.

8 DR. PARTIN: That would be great if
9 you could send that out to us.

10 DR. LANGEFELD: Okay.

11 DR. PARTIN: I have a question. On
12 page 9 where it talks about the Plan, this is the Plan
13 that's being developed now?

14 DR. LANGEFELD: This is what we call
15 the straw person. So, it's kind of a high-level
16 description of some of the things that the discussion has
17 coalesced around. And some of these things are things
18 that have been in place or neighboring states have done
19 and some of their work as well. But your question is?

20 DR. PARTIN: So, this is where some of
21 these standards that we're looking at implementing at some
22 point. And, so, the idea is, then, to look at each of
23 these things and see how they can be implemented through
24 the other -- the components of the quality, the workforce
25 and the ---

1 DR. LANGEFELD: You're exactly right.
2 So, here, let me just describe. So, patient-centered
3 medical home, you may be involved. There's a lot of
4 activity around patient-centered medical home. It's not a
5 new concept. But it's more of an operational model about
6 how you create some efficiencies and effectiveness and
7 processes in a practice.

8 And, so, as we think about that,
9 historically, what's happened, those initiatives have
10 either been funded and supported by one commercial payor
11 over here or maybe another self-insured group who's doing
12 it with their ASO provider over here or Medicare is
13 providing some support over here for a different
14 initiative.

15 The concept is how do we get all of
16 those payors together and providers together and say
17 here's the model that creates both efficiency and better
18 outcomes. How do we align the economics around that and
19 the processes around that across all payors so that we
20 don't have to think about it; we just focus on providing
21 the best care we can. Does that make sense?

22 DR. PARTIN: Uh-huh, uh-huh
23 (affirmative).

24 DR. LANGEFELD: The same is true for
25 ACO. ACO by definition is a Medicare initiative, but it's

1 a concept to say how do you take an integrated system and
2 have that system provide the full spectrum of care. And
3 to do that, it should be more than just Medicare. What
4 about Medicaid? What about the commercial payors? How do
5 we create an economic model that supports and aligns
6 incentives economically and from a support standpoint so
7 that we can just focus on the best patient care.

8 DR. PARTIN: So, you'll be looking at
9 how to get all of those separate groups to work together
10 as one to meet these goals?

11 DR. LANGEFELD: Correct.

12 DR. PARTIN: Okay, thank you. Any
13 other questions?

14 MS. WHITTAKER: I just have a comment.
15 I know in Ohio County, you know, as far as dental
16 providers, that is huge in our area, especially with ---

17 DR. LANGEFELD: You said dental
18 providers?

19 MR. WHITTAKER: --- Medicaid. And,
20 you know, the nearest orthodontist is E-town. And to get
21 those kiddos up there once or twice a month or back and
22 forth, it's a challenge.

23 DR. LANGEFELD: Yeah, very important
24 point. Because, again, as we think about this, not just
25 Medicaid but our communities and everyone in our

1 communities, we have to think about people in the most
2 holistic way. What are their behavioral health needs or
3 psychosocial needs or oral health needs or physical health
4 needs, their social needs, period. We have to think about
5 all of those things. We can't just say we're just going
6 to take care of this part.

7 DR. NEEL: Thanks, John.

8 DR. LANGEFELD: Okay.

9 DR. PARTIN: Thank you very much.

10 Okay, moving right along, we'll go ahead to the TAC
11 reports. Okay, Behavioral Health.

12 DR. SCHUSTER: Good morning. Sheila
13 Schuster. Actually, our Behavioral Health TAC did not
14 meet in July; the first time ever. We gave ourselves a
15 vacation. I do have a couple of comments, though. First,
16 to thank Barbara Epperson and the MAC for making the
17 binder available online. We were able to send that out to
18 our TAC members, and that's a huge help. So, kudos to
19 Barbara for doing that and to you all.

20 I also want to thank the Department
21 for Medicaid Services. I don't always come and do my
22 positive M&Ms. So, I'm going to do that to start off with
23 -- for the focus in the new contracts on some of the
24 behavioral health issues and some of the requests that we
25 had made as well as some of the other TACs. Certainly,

1 the standardization of forms is going to be very, very
2 helpful and a consistent medical necessity standard. We
3 certainly applaud the emphasis on what we call a warm
4 handoff of those with severe and persistent mental illness
5 at the point that they're discharged from the hospital and
6 how important it is to get them engaged in community-based
7 services asap.

8 While we applaud the emphasis on an
9 adequate provider network, I have to express some concerns
10 about the lack of specificity. To read that language
11 would make it seem that every behavioral health provider
12 is like every other behavioral health provider, which is
13 simply not the case. We know we don't have enough
14 prescribing behavioral health providers; psychiatrists and
15 mental health APRNs. There needs to be an emphasis on
16 that. Some of the services like psychological testing can
17 only be done by psychologists; and, yet, there's no
18 distinction, again, with just a generic number of
19 behavioral health providers.

20 I'm a child clinician. I think child
21 people are different than adult people. And Dr. Neel, I
22 think, would -- we've always been such good friends. I
23 mean, people that deal with kids do that. And people that
24 deal with adults and their issues very often don't know
25 kids and don't feel comfortable with them. So, some

1 distinction around that. And now with the substance use
2 disorders being added, we really need to be sure that
3 we've got those providers.

4 I'm happy to report that the licensure
5 law for alcohol and drug counselors finally passed after
6 five sessions, and which is written the regs. And, so,
7 we're going to see those people included in the State
8 Plan.

9 I also wanted to ask a question. That
10 is that an early release about what these contracts were
11 going to have was that there was going to be a requirement
12 that the MCOs not use a subsidiary or a separate company
13 for their behavioral health. And that's one of our
14 complaints has been that there's not been integrated care
15 because they have farmed out the behavioral health. But
16 I'm not sure that that's actually in the contract.

17 COMMISSIONER LEE: We didn't
18 (inaudible) any subcontract use.

19 DR. SCHUSTER: Well, that's
20 unfortunate, I think. It was in one of the early press
21 releases about what was going to be in the contract was
22 the requirement around that, unless I completely misread
23 that. I just wanted to ask you about it.

24 Dr. Neel and Dr. Partin asked
25 questions about credentialing. And on behalf of

1 psychologists, which is a group I know the most about, I
2 think there's several issues and several reasons why
3 there's not been the uptake in terms of people joining the
4 networks.

5 You have to remember that for 48
6 years, privately-practicing behavioral health providers,
7 other than psychiatrists, could not be Medicaid providers.
8 So, there's a huge history and education to overcome here.
9 And for lots of good reasons, that was limited to the
10 Community Mental Health Centers. So, opening up the
11 network was great. But we're only 18 months into this,
12 and you've got 48 years of history. And we're still
13 trying to get the word out to our members, as are the
14 other professional organizations, that you can now sign
15 up.

16 The sign-up is more complicated
17 because you have to be credentialed both by Medicaid and
18 by each of the MCOs. And the same concerns that you all
19 raised, that Sharon raised, you know, people send in their
20 stuff and, then, they don't hear from the MCO and, then,
21 they hear 60 days later that it was not complete or
22 whatever. We're looking at months and months, as I am
23 hearing anecdotally anyway. So, we probably need to get
24 more specific information and get that to you,
25 Commissioner.

1 The other issue, quite frankly, is the
2 low reimbursement rate. You know, if people are going to
3 go through all of that trouble and there's a kind
4 Zeitgeist out there, whether it's accurate or not, but
5 that very often people who are newly-insured or people
6 that are newly on Medicaid particularly may not keep
7 appointments with the same degree of regularity as some
8 others who are more used to coming and making appointments
9 and keeping those appointments.

10 In most cases, behavioral health
11 professionals make those for hour long periods. So, if
12 that patient doesn't come, that's a huge problem. And you
13 can't schedule multiple people for the same time slot when
14 you're going to schedule a 50- or 55-minute hour as we
15 call it for behavioral health services.

16 And, finally, I'd like to address
17 Peggy. And, again, I thank you, Peggy, because you're
18 always so willing to bring personal situations here. And
19 I think the MAC and the Commissioner and everyone here
20 needs to hear those. This is tricky stuff. The substance
21 use disorders, the addictive disorders, as you all are
22 newly covered by Medicaid, -- remember, traditional
23 Medicaid did not cover that except for youth and pregnant
24 women. So, we've got this whole new population now. We
25 are just getting providers on board.

1 a substance use disorder. That is not parity unless they
2 also have an arbitrary 15 days for somebody who goes in
3 the hospital for congestive heart disease. And I've never
4 seen those kinds of day limits put into a policy.

5 So, I just want to encourage you to
6 really push on that because there has to be parity. It's
7 the federal law before we ever had the Affordable Care
8 Act. It includes all self-insured plans. And it also
9 applies to Medicaid and to those qualified health plans.
10 So, I really encourage you to speak up, as you always do
11 on behalf of your daughter and others who are caught in
12 that. Because I think we're very used to hearing the
13 insurers, oh, well, there's a limit, we only do so many
14 sessions or we only do so many days. And on the
15 behavioral health side -- that's both mental illness and
16 substance use disorders -- there are no limitations --
17 arbitrary limitations on days and visits.

18 MS. ROARK: I would like to address
19 some of that. There was a sports center rehab in
20 Lexington. They told me they had to reduce 24 beds I
21 think down to 14 or 16 before the MCOs would pay for it.
22 That is sad. We don't have enough beds. We don't have
23 enough. And now I heard -- this could be wrong, correct
24 me -- that the Governor has released more money for people
25 to go to jail than to rehabs. We need help for rehabs.

1 DR. SCHUSTER: No, no. Let me ---

2 MR. ROARK: Is that ---

3 DR. SCHUSTER: At least on the heroin
4 bill, Senate Bill 192, there was \$10 million put in for
5 treatment. And, actually, they have really worked hard to
6 keep those folks -- particularly the first offenders who
7 are with possession, not with selling, -- we make that
8 distinction -- not to go to jail but to go to treatment.
9 So, no, I think that's incorrect information. The
10 Legislature, both D's and R's and House and Senate and so
11 forth, really worked hard to come up with and they did
12 come up with an initial infusion of \$10 million to go into
13 treatment with more to come.

14 MS. ROARK: That's good to know. And,
15 today, my daughter is clean. I had the Casey's Law. It
16 took me ten times to go to Court to get help for my
17 daughter. That's a shame. And she took the Vivitrol
18 shot. She's wanting to get back in society and get a job
19 and get back and find these resources to help her get back
20 in society and live a normal life. But in the meantime,
21 she's got to work on her mental health and her heart
22 condition.

23 DR. SCHUSTER: Right.

24 MS. ROARK: She got on heroin, and she
25 got on the needle and damaged her heart. Now, her feet

1 swell s out.

2 DR. SCHUSTER: Yeah, it's
3 heartbreaking. And the problem is that with so many of
4 these chronic illnesses, but addiction especially, there
5 is frequent relapse, as we know. So, it's not a one shot
6 cures the problem.

7 MS. ROARK: And I don't want to just
8 speak, like you said, on my daughter; because I'm on these
9 closed Facebook pages of the Casey's Law, Parents Against
10 Heroin, and I have like lots of questions and stuff of all
11 parents that's needing help besides me.

12 DR. SCHUSTER: Mr. Wright.

13 MR. WRIGHT: First off, let me applaud
14 you for being a long-time advocate and working with
15 children. As a professional school guidance counselor, I
16 love that you work with children and that you're so
17 passionate.

18 DR. SCHUSTER: They say that's why I
19 work well with Legislators.

20 MR. WRIGHT: Well, good. That's
21 important. I'm fairly passionate about school children,
22 doing that for 17 years; but, also, both my daughters who
23 have severe intellectual and developmental disability. My
24 comment was something you just said about the parity. I
25 often find when I'm making consultation referrals to

1 outside mental health agencies, particularly on some
2 children who may need some residential psychiatric
3 treatment, there seems to be this day period of time when
4 we have to see them transition back into the school
5 because of the funder. Am I hearing you say that that's
6 not ---

7 DR. SCHUSTER: That's where the very
8 tricky issue about medical necessity comes in. Because
9 what will happen is that the treating -- and in this case,
10 probably treating psychiatrist -- is saying I think this
11 child needs to be in the hospital for an additional day or
12 two days or three days; and the MCO, then, will say, well,
13 an extension of the stay does not meet our medical
14 necessity criteria. What I'm talking about is the
15 a priori or up-front limitations ---

16 MR. WRIGHT: Okay, got you.

17 DR. SCHUSTER: --- that says no child
18 is ever going to get more than three days in the hospital
19 for this diagnosis.

20 MR. WRIGHT: So, not a ---

21 DR. SCHUSTER: But a case-per-case ---

22 MR. WRIGHT: --- predetermination.

23 DR. SCHUSTER: --- has to be -- yeah.

24 It has to be done on medical necessity. And that's what
25 we have the big fights with the MCOs about, quite frankly.

1 You know, where the treating professional is fighting with
2 maybe somebody at the MCO who has no behavioral health
3 background, who is looking at a computer screen and making
4 those determinations.

5 Now, most of the MCOs have been very
6 good about saying we will have an in-person -- you know,
7 an actual person that you can talk to -- that the provider
8 can talk to. What we want is peer-to-peer kind of
9 affirmation or denial. So, if you have a child
10 psychiatrist, they would really want to talk to a child
11 psychologist at the MCO end and have a clinical discussion
12 about this child and what they need.

13 MR. WRIGHT: Good stuff. Thanks.

14 DR. SCHUSTER: Thank you all.

15 DR. NEEL: Sheila, before you go,
16 about credentialing, there was a bill and it had to do
17 with the mental health bill that had to do with the mental
18 health practitioners had to be credentialled within 60 days
19 or something. Did that bill pass? I know it was in there
20 somewhere along the line. It was to facilitate
21 credentialing with the new payment for mental health
22 practitioners. Does that jog a memory somewhere of
23 somebody?

24 DR. SCHUSTER: I'm getting old. I
25 don't remember that one.

1 MS. CECIL: I'm Veronica Cecil with
2 Department of Medicaid.

3 DR. NEEL: Am I way off on that?

4 MS. CECIL: What they did in that
5 legislation is require a 45-day processing of applications
6 if the provider is a substance use provider.

7 DR. SCHUSTER: That was it, yeah.

8 MS. CECIL: So, what we're doing
9 internally in Medicaid is asking providers just to affirm
10 that they're going to provide substance use so we can
11 expedite their processing. And the same for the MCOs.
12 The MCOs, we have clarified to them the same. If it is a
13 provider for substance use services, that they are
14 mandated to process those applications within 45 days.

15 DR. SCHUSTER: That was actually in
16 the heroin bill, I think.

17 MS. CECIL: That's correct, Senate
18 Bill 192.

19 DR. NEEL: I knew it was in somewhere.
20 Okay. And we shoot ourselves in the foot sometime. In
21 the nurse practitioner bill, we had an unintended
22 consequence. We put in that for the first year they're in
23 practice, they can't prescribe ADHD medications. And I
24 don't know why that was put in there because that's
25 affected my own practice because a new -- and if one in

1 ten kids have ADHD, it's a big deal.

2 MS. CECIL: You need to talk to KMA.
3 That was a compromise with them.

4 DR. NEEL: I understand that, but
5 that's what I'm saying.

6 DR. SCHUSTER: We'd be happy to
7 uncompromise that.

8 DR. NEEL: It was our own foot that we
9 shot. And I didn't realize it until we put it in there.
10 But that is something we shouldn't have done. There was a
11 fear that they would prescribe and not be mature enough, I
12 guess, to prescribe the drugs; but it's really been an
13 effective thing.

14 DR. SCHUSTER: Yeah, and the data does
15 not ---

16 DR. NEEL: No, exactly.

17 DR. SCHUSTER: --- bear that out at
18 all. Thank you all very much.

19 DR. NEEL: We'll take the bullet on
20 that one.

21 DR. SCHUSTER: Thank you, Dr. Neel.

22 DR. PARTIN: Okay, Children's Health.
23 Consumer Rights and Client Needs. Dental. Nursing Home.
24 Home Health.

25 MS. BRANHAM: Yeah.

1 DR. PARTIN: You got something?

2 MS. BRANHAM: I got something. The
3 Home Health TAC met yesterday. And we have a few things
4 going on simultaneously, and I think providers across the
5 state are having difficulty in complying with guidance set
6 forth by the Cabinet and Dell (sic) in regards to the MWMA
7 on-boarding and the Home- and Community-Based Waiver
8 Conflict-Free Case Management.

9 In our discussion yesterday, providers
10 have been set with the task to on-board, demographic
11 information for patients receiving services; and that has
12 been something that has been difficult to do. We have a
13 deadline of August 17 to have the demographic information
14 for the patients being served entered. Only the problems
15 that have been encountered have been something that I
16 don't think that was foreseen. And those problems
17 generally are around the demographic information for
18 patients that are on-board receiving services when that
19 information is entered.

20 The information that DCBS has given
21 the Cabinet to enter into doesn't always agree with
22 perhaps Social Security Administration, or perhaps the
23 address is different. So, the current information that
24 each provider has on every patient may be different than
25 what has been loaded and pre-populated into the system;

1 and it's causing a lot of time, effort and energy.

2 And we were told yesterday about half
3 of the issues have been worked out and about half should
4 be worked out within the next week. And I guess when we
5 enter the information and we look at the individuals'
6 cards, their address and they've been on staff -- I mean
7 they've been on care via paper and we enter that into the
8 system on this on-boarding system and it doesn't jive,
9 we're kind of at a holding pattern and we're not able to
10 go forward.

11 So, the Home Health TAC has the
12 recommendation to the MAC to ask that the data be looked
13 at and the providers' ability to enter this information be
14 moved up from August 17th to August 31 to allow them
15 additional time to look at the data that may have been
16 pre-populated that doesn't jive.

17 One example is a number entered into
18 the system -- on-boarding system by either DCBS or
19 whomever does not agree with what the patient has in their
20 hands and what maybe Social Security Administration has in
21 their hands. And we're being asked to do a lot of that
22 back-tail into -- you know, this vulnerable population
23 doesn't have the ability to get these kinds of things
24 corrected. So, we'd like to see this deadline moved out a
25 couple more weeks to allow Dell (sic) and the Cabinet to

1 get the information entered or to look at the information
2 and at least be caught up. If they've got 50% of those
3 backlog questions -- problems being answered, that they at
4 least get finished with those before we're required to
5 start entering that information into the on-boarding.
6 That's our first recommendation; to be moved from the 17th
7 to the 31st.

8 The second recommendation would be
9 that regarding the Pickle Amendment for those folks that
10 were identified that had a liability of some money
11 beginning in 2008 and should not have had that liability,
12 that a directive be put out to providers by the Cabinet
13 with a step-by-step flow sheet that we know exactly what
14 to do.

15 Point being that individuals that have
16 paid liability for a number of years, there can be a
17 significant amount of money owed to the patient. We have
18 reports that some patients are holding the checks that
19 providers have repaid them the liability and they're
20 afraid to put it in their account or to cash it or to do
21 anything with it because they think that it's going to
22 affect their current eligibility.

23 These individuals have not been given
24 the information who were identified in this reconciliation
25 regarding the Pickle Amendment that, indeed, the money is

1 yours; the provider will be reimbursing it; and it does
2 not affect your eligibility. And on the providers' side
3 that if you didn't pay this money because you weren't able
4 to collect it, that you shouldn't have to reimburse it.
5 So, a directive from the Cabinet to not only the clients
6 that have been identified that fall under the Pickle
7 Amendment but also the providers themselves that we have a
8 clear, concise directive on what to do. That's the second
9 recommendation.

10 And the third recommendation is
11 entering into the software, the portal, it was determined
12 yesterday that there's no way -- if Mr. Jones requests an
13 assessment to be performed and we go out to perform the
14 assessment and we start entering it into the online
15 portal, it declines an assessment to be -- it will not
16 allow you to enter the assessment.

17 And in the system that has been set
18 up, even the Cabinet does not have the ability to say if
19 that client is under an assessment level of care. They
20 can't tell us, and we can't tell them. And the patient
21 can be adamant that nobody else has given us this
22 information; Yet, when we try to enter -- nobody else is
23 working with me to get services. Yet, when we try to
24 enter the information through this on-boarding portal,
25 that the Cabinet doesn't have the ability to know if these

1 people are actually under a Plan of Care or if it's a
2 glitch.

3 So, our directive is that we have the
4 Cabinet look at adding something to the software so that
5 any provider can call a number or email to say is this --
6 or something pop up that says they're already in the
7 assessment phase of this by another provider. And we
8 fished out yesterday that that was something that hadn't
9 been considered. And if the Cabinet can't tell that
10 somebody is under a Plan of Care and it's just kicking it
11 out and the provider can't tell, then, I see this
12 fragmented care getting much worse as we go down the road.

13 DR. PARTIN: Thank you.

14 MS. BRANHAM: So, those are my three
15 recommendations for the MAC.

16 DR. PARTIN: And I would like to add
17 for the first recommendation since that's time-sensitive
18 that maybe we could get a response from DMS before 30
19 days.

20 COMMISSIONER LEE: Absolutely.

21 DR. PARTIN: Thank you. Hospital
22 Intellectual and Developmental Disabilities.

23 MS. DEMPSEY: Good morning. I'm Patty
24 Dempsey with of Arc Kentucky. Glad to be here today. We
25 had our Technical Advisory Committee on Intellectual and

1 Developmental Disabilities that met on July 10th in
2 Frankfort at the Cabinet for Human Resources. The meeting
3 was shortened a little bit. So, actually, our
4 recommendations are kind of short today because it was the
5 tornado. There was a tornado warning.

6 So, about I guess an hour into the
7 meeting or so, there was a tornado warning -- siren; and
8 everybody had to go to the basement. And, of course, when
9 we all got -- we got separated. So, when we got to the
10 basement, nobody wanted to continue the meeting because
11 everybody was watching for clouds in the tunnel.

12 So, anyway, our report is a little bit
13 shorter today. But I do want to -- some of the things
14 that we actually discussed in our meeting has actually
15 already been brought up today. But one of the things we
16 do want to do is thank the Department for Medicaid
17 Services and the Cabinet for the very good news today
18 about the Waiver Services and about the Waiver spots --
19 the Waiver allocations that are going to be released
20 tomorrow for the Michelle P. Waiver and for the Supports
21 for Community Living Waiver because our TAC primarily
22 deals with the Waiver world.

23 We are a mixed bag in our group. We
24 are made up -- our TAC is made up of consumers,
25 self-advocates, advocates, advocate representatives,

1 private providers, non-profit providers, advocacy groups.
2 So, we are kind of a mixed group. And, so, we're kind of
3 all over the place sometimes. But we are very thankful
4 for those spots that are going to be released because one
5 of the concerns -- and this is going to sound like old
6 news to you all, old record -- but we're extremely
7 concerned about the Michelle P. Waiver waiting list; and
8 that's already been brought up. The numbers have already
9 been given.

10 It's in our information that there's
11 over 4,000 people on the Michelle P. waiting list;
12 probably 10,000 -- probably over 10,000 are already
13 getting services. So, along with that waiting list that's
14 continuing to grow rapidly with families not getting
15 services, with advocates and self-advocates, individuals
16 not being able to access some of the services comes a
17 concern of the need -- and we've talked about this before
18 to this Committee and thank you all very much for
19 listening -- but the lack of an appropriate assessment
20 tool for children.

21 We have discussed that with the
22 Department for Medicaid. And thank them for being open
23 and listening to us when we have so many questions. But
24 there is a dire need for an assessment tool for children
25 for the Michelle P. Waiver. And, again, as I said, the

1 concern on the growing waiting list is a major concern.
2 The Supports for Community Living Waiver has a waiting
3 list, too; but that list is not growing as rapidly as
4 Michelle P.

5 Another concern that we had that we
6 talked about in our committee in addition to the
7 assessment tool was the number of hours. Which, actually,
8 this goes back to -- actually, this is kind of new, I
9 think, to this group. But the 40-hour regulation in the
10 Michelle P. Waiver, the Administrative Reg, is a concern
11 to families and self-advocates receiving services,
12 individuals, because CDL recipients -- Consumer-Directed
13 Option in the Michelle P. Waiver -- recipients have been
14 notified that their hours are going to be limited to a
15 cumulative of 40 hours.

16 So, that is in the regulation.
17 However, in many cases, it does not affect -- and that
18 requirement is necessary or it's necessary to have
19 additional hours for some families because it's supposed
20 to be flexible hours needed for people to be able to have
21 the services they need but not to increase the budget.
22 So, that's another concern from our group.

23 One thing that's already been talked
24 about is the portal. We have concerns that the portal was
25 -- actually, the family members -- that this goes into

1 effect at the end of the year and that family members are
2 also and recipients of services are also going to be
3 required to use the portal in addition to the providers.

4 We have discussed that with Medicaid,
5 and we've been told that that is going to be on a
6 voluntary basis for individuals and for families. So,
7 that was a concern we had; that families not having the
8 technology and the availability to be able to participate
9 in that portal service.

10 Another issue that was brought up was
11 the patient liability that's already been mentioned by
12 Home Health. And in addition to the issues already
13 expressed, what we've run across is some individuals that
14 paid patient liability for a number of years and are now
15 due a refund are not receiving that refund. So, we have
16 heard reports that there's some people that have been
17 waiting as long as 14 months. And, then, there's not a
18 time frame when they will be able to expect that funding.

19 MS. BRANHAM: Patty, I have a
20 question.

21 MS. DEMPSEY: Uh-huh (affirmative).

22 MS. BRANHAM: That audit hasn't been
23 going for 14 months, has it?

24 MS. DEMPSEY: I don't know. We just
25 heard that this week; that it was like ---

1 MS. BRANHAM: Has it, Veronica?

2 MS. CECIL: No.

3 MS. BRANHAM: No, I didn't think so.

4 MS. DEMPSEY: Okay. It's not been
5 going that long?

6 MS. BRANHAM: No. When did the first
7 letter go out that a client has been identified that their
8 liability was ---

9 AUDIENCE: (Inaudible).

10 MS. CECIL: Really? Okay.

11 MS. DEMPSEY: Is it 14 months?

12 AUDIENCE: Yes.

13 MS. BRANHAM: Well, there you are.

14 MS. DEMPSEY: So, they have continued
15 to ask questions. And I think most of their questions
16 maybe have gone through their provider agency. So,
17 anyway, there is some concern from that end that some
18 people are beginning to receive their payments that do;
19 some people are not. So, that was one of the issues that
20 we had there.

21 Another is the -- as most of you have
22 probably read about, there's a particular concern to the
23 provider agencies that are involved in our group is the
24 state audit and provider recruitment of over
25 \$2. (inaudible) million -- \$2.5 million for lack of

1 documentation identified in the Money Follows the Person
2 program. So, that was discussed. Provider agencies
3 discussed at our meeting that they were concerned that
4 smaller providers might be forced out of business if
5 they're required to pay that recoupment cost.

6 Another issue was -- and probably my
7 final one; and, then, we have three short recommendations.
8 Is the EPSDT Program with a change from the EPSD Program
9 going from Michelle P. Waiver in some instances to the
10 State Medicaid dollars has resulted in some disruption of
11 services. And, also, there was some concern among family
12 members that the therapy services that are required
13 annually were going to be cut back. So, we have issued
14 those questions to the Department of Medicaid Services as
15 well.

16 So, to sum it up, our recommendations
17 to the MAC today -- and thank you very much for listening
18 and for responding to our recommendations that we've had
19 in the past -- is that the TAC recommends that the
20 Department for Medicaid Services stop recoupment for minor
21 documentation errors and examine the monitoring process
22 for traditional providers that are involved in the Money
23 Follows the Person funding and to look at another way to
24 handle infractions and recoupment.

25 Number two, we recommend and suggest

1 that the Department for Medicaid Services develop an
2 appropriate tool for evaluation for children's eligibility
3 for Michelle P. Waiver.

4 And number three, we recommend that
5 the Department for Medicaid Services re-examine the
6 Michelle P. Waiver consumer-directed option, CDO, 40 hours
7 per week limit to allow for flexibilities within the
8 budget. Those recipients using more than 40 hours are
9 still within their budgets. So, it's not actually an
10 increase to Medicaid dollars. And that's it; all we've
11 got.

12 DR. PARTIN: Thank you.

13 MR. WRIGHT: Couple of comments. I
14 used to chair that TAC. So, it's good to see you, Pat.

15 MS. DEMPSEY: He really did and did a
16 good job.

17 MR. WRIGHT: I did hear a couple of
18 concerns, too, that I wanted to bring before the MAC
19 today, too, related to Michelle P. It was in regard to
20 supply budgets, and this was directly from KIPDA. KIPDA
21 said that the supply budgets now are going to be -- they
22 used to be every six months, and now they're going to end
23 with the level of care. Correct me if I'm wrong, but they
24 were talking to me about this yesterday.

25 And there are weeks when the budgets

1 are -- there seems to be a gap in service now. So, I
2 guess the new LLCs are going to be with those that they're
3 annual; but there's been significant gaps in
4 reimbursements for services to the provider agency. And
5 KIPDA brought this to my attention yesterday. So, I said
6 I would be here. I told them I would be quiet the first
7 meeting, but I had to bring that to the attention.

8 Then, there's still some date concerns
9 with cleaning up some dates when things can be approved.
10 I'm hearing that from just provider agencies, case
11 managers, support brokers. And it seems like that
12 particularly on recertifications, there seems to be some
13 lag behind end of plans, primarily through some of the
14 Comp Care agencies. And there, again, is potential for
15 gaps in services. And, so, we're just trying to eliminate
16 any of those potential gaps in services.

17 And EPSDT was on my radar but you've
18 covered that, Patty, and the hours, 40-hour limitation.
19 But correct me if I'm wrong, that does not exclude
20 respite? Respite is above and beyond the threshold of 40?
21 Correct me.

22 MS. DEMPSEY: It excludes respite.

23 MR. WRIGHT: It excludes respite.

24 AUDIENCE: That doesn't include
25 respite. The 40 hours does not include respite.

1 COMMISSIONER LEE: We'll have to look
2 at the reg.

3 MS. DEMPSEY: I had that it excluded
4 respite.

5 MR. WRIGHT: So, respite could be
6 above and beyond, but you're saying it's not?

7 COMMISSIONER LEE: We'll have to
8 double-check.

9 MR. WRIGHT: All right, good deal. I
10 think that's an important thing to take a look at as well.
11 I like the recommendations.

12 DR. PARTIN: Eric, were those
13 recommendations that you were making or just comments that
14 you were making?

15 MR. WRIGHT: Currently, I don't have
16 any recommendations regarding the dates or the other thing
17 with supply budgets. It's something to take a look at,
18 though. But I think the recommendations from the TAC will
19 be suffice.

20 DR. PARTIN: Okay, thank you.

21 MS. BRANHAM: And just for the record,
22 Home Health's will be in writing, Barb, by close of
23 business tomorrow.

24 MS. EPPERSON: Thank you.

25 DR. PARTIN: The Nursing TAC did not

1 meet. Optometry.

2 DR. WATKINS: Optometry TAC met last
3 Thursday, July the 16th. You all have the minutes already
4 provided in your binder. And although we did have an
5 extensive meeting that lasted for three hours that did
6 have doctors from across the state as well as all of the
7 members from the different MCOs there as well as the
8 subcontractors from all the vision providers
9 representative there. So, we did have a very informative
10 meeting there. So, we were very well in getting answers
11 to all of our previous recommendations. So, I won't labor
12 that with all of you.

13 We only have one recommendation that
14 was brought forth from that, although it is a little bit
15 long. I will read it to you. It is also in your binder,
16 but I did get a last-minute email from our office last
17 night that has just slightly different wording. So, I'll
18 read that to you today.

19 The Optometric TAC would request for
20 Medicaid to look into the reporting of an optometrist's
21 patient encounters and the MCO's reporting of the
22 optometrist's patient encounters to the Kentucky Medicaid
23 EHR Incentive Program. A couple of optometrists reported
24 several -- let me get this right. A couple of
25 optometrists reported issues of not being able to receive

1 approval because the optometrists attested with their
2 group Medicaid number of patient encounters to Medicaid
3 EHR Incentive Program but ended up being denied approval
4 because the number that the MCOs provided were only the
5 individual optometrist's Medicaid encounters. No group
6 encounters were reported. The TAC would think there is a
7 way for the MCO or the vision subcontractors to send
8 reports of both the individual and the group patient
9 encounters to the Medicaid EHR Incentive Program. So,
10 whatever way the doctor chooses to attest to, the group
11 practice or the individual patient encounters would be
12 able to match.

13 A little bit of explanation on this,
14 in 2012, the optometrist that I practice with, she not
15 only practices with me two days a week, she also practices
16 with another doctor two days a week. So, although I am a
17 solo practitioner and I practice in my practice for five
18 days a week, I only have one MPI number. So, when I was
19 under traditional Medicaid and she was under traditional
20 Medicaid, we both just had the one number. Okay. When we
21 got our MPIs, I had one MPI number. Since she works in
22 two offices, she has two MPI numbers. She has a group MPI
23 and she has her individual MPI. Okay?

24 When we went to try to get our EHR
25 Incentive dollars saying that we were using computerized

1 systems to now comply with -- moving forward, that we were
2 using Electronic Health Records to get our Incentive
3 dollars, that we are Medicaid-eligible doctors, meaning we
4 see at least 30% Medicaid patients. In my practice in
5 Russell Springs, Kentucky, we were seeing approximately
6 40% Medicaid patients. In her other practice in Mt.
7 Vernon, Kentucky, they were seeing about -- her doctor was
8 saying about 29% or so Medicaid patients. So, he was
9 saying I think I'm going to have to do Medicare. Okay?

10 But in her case, since she was there
11 two days a week and in my practice two days a week, she
12 still qualified to be Medicaid. Okay? But when she went
13 to file for her Medicaid Incentive dollars in 2012, she
14 qualified; but they told her you have to add your numbers
15 together. When you turn in your numbers, you have to add
16 your encounters together. The people you saw in Mt.
17 Vernon and the people you saw in Russell Springs, all
18 those people -- all those numbers have to add up. And
19 coming straight from Medicaid, it did add up; because
20 those were all Medicaid patients. So, we got her money in
21 2012; and I got my money in 2012.

22 Well, in 2013, I used my individual
23 MPI number; and I got my money, no problem. In 2013, she
24 turned in her information; and she thought everything was
25 still fine. And she got information back saying it didn't

1 add up; you're not going to get paid.

2 Well, by this point, by the time she
3 got the information saying she wasn't going to get paid,
4 it was too late to turn around and switch over to become a
5 Medicare-eligible provider because the window had been
6 closed. And she had to wait till the next year to turn
7 around to try to get money from them.

8 Anyone that's ever done this, we're
9 talking thousands of dollars here; like seven, 8,000
10 dollars. And I'll go ahead and tell you that this year,
11 she tried to file Medicare; and she couldn't figure out
12 how to do it or the time ran out or something. Anyway,
13 she ended up not getting that money either. And now that
14 she's not gotten Medicare for a year, she's out of the
15 loop.

16 And they've told her that not only are
17 you not eligible to do that, you're going to start getting
18 fined because of the fact that you're not showing us that
19 you're doing your EHR Incentive. We don't have proof that
20 you're doing your Electronic Health Records. So, you're
21 going to be starting a fine on your Medicare money that
22 you're not doing Electronic Health record billing.
23 They're going to start keeping 2% of her payment.

24 So, we need to get this problem fixed.
25 Now, we have been told by Medicaid that they do not have

1 this rule; that once you're out of the loop for a year
2 that you can come back into the system and still try it
3 again. So, we have hope that she can still come back into
4 Medicaid and still get paid as an EHR Incentive Program
5 participant and that we can apply for 2015, I guess it
6 would be, when they get the system set up. But this is
7 two years worth of money that has been lost due to this
8 problem.

9 But what had happened was that the
10 encounters that were turned in would be from just one
11 office and not from the two offices. So, it's looking
12 like that they're not seeing enough people to substantiate
13 that they are a true Medicaid provider; and the data is
14 not being turned in and added up to make it look like that
15 they're an actual Medicaid provider. It should be easier
16 than that. That's our only recommendation.

17 Oh, and I do want to say that one of
18 the things that did come about at our meeting was that
19 there was a complaint from some of the doctors. If you'll
20 remember back, a year or so ago I brought up a kit that we
21 had had some issue with -- a frame kit that was from
22 Avesis, one of our subcontractors for vision -- that we
23 thought was a little bit small number of frames; that we
24 asked for some new frames, some larger frames. And we had
25 voiced a complaint.

1 And we brought up again at the meeting
2 that we didn't have any new frames. And we were told that
3 there were some new frames, and there were some bigger
4 frames, and that we had to just let them know that we
5 needed some more frames, and they would be provided to us.
6 So, I asked. And, lo and behold, Monday at my office was
7 delivered a tray of new frames that are larger; and they
8 even have spring hinges. So, kudos to the people at
9 Avesis for coming through. My staff were celebrating.
10 And, so, thank you. Appreciative.

11 DR. PARTIN: Thank you. Pharmacy.

12 MR. ARNOLD: Yes. Hi.

13 DR. PARTIN: Hi.

14 MR. ARNOLD: I'd like to ask would you
15 mind to come up and just sit with me up here. Samantha.
16 You don't have to talk. I want to recognize you. Again,
17 my name is Jeff Arnold. It's a pleasure to be here with
18 the MAC and also with the Cabinet. And I'm the Chairman
19 of the Pharmacy Technical Advisory Committee, Kentucky
20 Pharmacy Association.

21 Thanks for coming up Samantha and Alan
22 because I just want to explain kind of how we're
23 approaching our due diligence, our research to come up
24 with thoughtful ideas really to cut costs and improve
25 patient outcomes. Alan is the Pharmacy Director for

1 WellCare. Each of the five MCOs have a Pharmacy Director.
2 So, the first entry into an MCO is through the Pharmacy
3 Director. Samantha is a Director of Pharmacy for the
4 Cabinet. I represent practicing pharmacists throughout
5 the State of Kentucky through our Association. So, if you
6 think about it, before we bring our recommendation --
7 which is not going to be today. We're doing our due
8 diligence to talk to the MCO and say how do we work
9 collaboratively and completely with the Cabinet to create
10 compliance for medication.

11 Ten percent of admissions to the
12 hospitals are due to drug non-compliance. Up to 50% of
13 patients don't take their medicine as prescribed by the
14 physician. The MCOs have mechanisms with case management
15 -- the Cabinet does as well -- talking to Medicaid
16 beneficiaries, the 1.2 million beneficiaries throughout
17 the state. But sometimes when you call them and talk to
18 them, they're like -- they're alarmed or they don't know
19 who you are. They may not be cooperative, or they might
20 be cooperative, in helping to manage their disease state
21 through medication analysis and discussion. So, what
22 we're looking at is a complete collaboration; the MCO, the
23 Cabinet and pharmacists.

24 Dr. Langefeld has said pharmacists are
25 ubiquitous -- that pharmacists are ubiquitous. They're in

1 every county. They're in every small community throughout
2 the State of Kentucky. So, how do we engage the
3 pharmacist who knows these individuals getting their
4 medications filled to have compliance as it applies to the
5 medication and the impact it has on its disease state?
6 So, what we're doing now is we're going to meet every
7 couple of months and really do our organizational
8 development to come up with a concept. And through that,
9 there will be reimbursement for the pharmacists for their
10 services.

11 Our Commissioner has discussed about
12 HEDIS, or it was discussed here, the Health Effective Data
13 Information System. And that's a mechanism to measure
14 quality and outcomes statistically. And if it's increased
15 year over year or compared -- or if there's an increase
16 compared to a national benchmark, there's a 1% value to
17 the MCO. So, the MCO does want quality standards met,
18 positive patient outcomes. And, of course, it's managed
19 care; but it also honestly can be managed cost
20 organization because we need to stretch every dollar we
21 can in the state.

22 So, I really just wanted to say thank
23 you to the MCOs and their respective Directors and thank
24 you to the Cabinet for having their representative of
25 Pharmacy there working with pharmacists to create the

1 mechanism to create better outcomes, at the same time a
2 lower costs. We understand -- how do you lower costs?
3 Take the medication accurately and correctly to avoid
4 further complications in your disease state; take the
5 medication timely; and have somebody to talk to if you
6 have an issue with that.

7 So, we're going to create a
8 demonstration project. Dr. Langefeld is coming to their
9 next meeting. We're going to talk about that as well.
10 And maybe we'll just start in a small community with an
11 MCO and a pharmacy or group of pharmacies, get the input
12 from the Cabinet and from the MCOs how to create a system
13 to get better compliance. But the key thing is, as HEDIS
14 would like to see, data information so we can measure the
15 outcomes.

16 Just three other points we talked
17 about. Of course, we try for generic medications to lower
18 costs. Work with the physician and, where possible, to
19 use generics. When a brand is necessary -- and it is more
20 expensive -- there a process called prior authorization.
21 So, the issue is it's Friday; it's nine o'clock at night.
22 They need a drug that's not covered on the formulary. How
23 do we get that to the patient timely and make sure it's
24 going to be reimbursable? So, again, working collectively
25 with all the MCOs.

1 pharmacy, once the manufacturer raises that price, how
2 quickly does the pharmacy benefit manager or the MCO
3 equally raise that price when the drug manufacturer raised
4 it? But the way to address that, we think, is directly
5 with the MCO through the Pharmacy Managers. When we bring
6 the recommendation here at our next meeting which I intend
7 to bring, I would hope to have the endorsement of the MCO
8 and the endorsement of the Cabinet with that
9 recommendation that we bring to the MAC to go to the
10 administration.

11 But just a brief review of kind of
12 what we're doing, I think it's very effective. And the
13 input, again, I'm going to again thank Samantha and Alan,
14 as a representative of the other MCOs. Their active input
15 with our pharmacists and with the University of Kentucky
16 College of Pharmacy, the Kentucky Pharmacy Association, I
17 think we're going to bring something valuable to maybe
18 show if we can all work together, you know, there can be
19 reasonable compensation where we can get good patient
20 outcomes. So, that's our presentation, our report. We do
21 not have an action item at this point, but we look forward
22 to bringing one back at our next meeting.

23 DR. PARTIN: Okay. Thank you very
24 much.

25 MR. ARNOLD: Thanks.

1 DR. PARTIN: Physi ci an TAC.

2 DR. NEEL: The Physi ci an TAC met thi s
3 last month, and we don' t have a recommendati on to bring,
4 but we discussed all of the subjects that mostly have been
5 discussed today. Everything from an explanati on of the
6 new contracts, recoupments, credentialing and paying for
7 99214s and 5' s.

8 DR. PARTIN: Okay, thank you.

9 DR. NEEL: We' ll continue to discuss
10 them.

11 DR. PARTIN: Podi atry. Pri mary Care.

12 MS. BEAUREGARD: Emi ly Beauregard wi th
13 the Kentucky Pri mary Care Associ ati on. I have a pretty
14 brief report for you all today. You should have it in
15 your binder, along wi th the mi nutes from May. We didn' t
16 get mi nutes from our July meeting in time to submit them
17 to you. I still haven' t received them, but we' ll submit
18 them whenever I get them.

19 We met on Thursday, July 9th at ten
20 o' clock at the Cabi net. And we actual ly had to adjourn
21 our meeting pretty quick ly. There weren' t enough DMS
22 staff there at the meeting present to discuss the items on
23 the agenda. So, we decided to adjourn because we weren' t
24 going to be able to accomplish anything. We hope that
25 that was just an exception and that in September we' ll be

1 back on track. But we do request that we get prior notice
2 if that is going to be the case in the future. We have
3 people traveling from pretty long distances for the
4 meeting.

5 But aside from that, we are just
6 resubmitting the recommendations from our prior TAC
7 meeting. I know there wasn't a quorum last time. I do
8 have a couple other requests that I just wanted to make.
9 And you can let me know if you think these need to be in
10 the form of a recommendation, but two of the items that we
11 talked about today -- or, actually, just one of the items
12 that we talked about today -- the recoupments for
13 retro-eligibility -- I think that the information that's
14 been shared has been very helpful for us to all understand
15 what the process is for being able to bill those to the
16 correct health plans, but I don't think that most
17 providers are aware of that.

18 So, I would just request that we have
19 a formal communication from DMS that kind of outlines that
20 caused some of those retro-eligibility issues and, then,
21 what the process is for rebilling just to make it simpler
22 and to sort of eliminate some of that confusion.

23 And, then, also something that hasn't
24 come up today but was part of the MCO contract is the
25 section on enrollment and disenrollment. There is some

1 language in there about disenrolling members if there's a
2 bad address. And I think that that's something -- now, I
3 actually had the benefit of being in a meeting with Lee
4 Guise on Monday and got a very good clarification on what
5 that was -- how that process was going to work. And I
6 think that same clarification would be very helpful for
7 all providers just so that everyone can be prepared and
8 that there won't be panic whenever they see that a member
9 has been disenrolled or is at risk of being disenrolled.
10 So, just having some of that information out I think will
11 really eliminate some issues and prevent some major
12 problems for Medicaid members and for providers as well.

13 I also just wanted to thank you for
14 the recommendation that you made on the limitation of the
15 99214 and the 99215 codes. That's something that's very
16 important to our providers as well and has been an issue.
17 And I think when we look at that value-driven care, you
18 know, and the triple aim, we really do want to focus on
19 managing those chronic patients and having the resources
20 to do so and, also, being able to accurately reflect the
21 status -- the health status of our patients. And, so, I
22 think having the accurate coding and having the ability to
23 get paid for the amount of time that you spend with a
24 patient is important to our members as well. So, thank
25 you for making that recommendation.

1 Aside from that, I don't have anything
2 else. If you all have questions for me.

3 DR. PARTIN: Would you write those two
4 items that you brought forward ---

5 MS. BEAUREGARD: The requests?

6 DR. PARTIN: --- as a recommendation?

7 MS. BEAUREGARD: Should it be a
8 recommendation?

9 DR. PARTIN: Yes.

10 MS. BEAUREGARD: Yes, I can do that.

11 DR. PARTIN: And, then, we can approve
12 that today.

13 MS. BEAUREGARD: Okay. I don't know
14 if I need to get approval of the TAC for that. Could I
15 just send it to you in writing ---

16 DR. PARTIN: We can make ---

17 MS. BEAUREGARD: --- after the
18 meeting?

19 DR. PARTIN: We can make it a
20 recommendation from the MAC.

21 MS. BEAUREGARD: Okay. That would be
22 great. Thank you.

23 DR. PARTIN: Would you write them out
24 for us?

25 MS. BEAUREGARD: Sure. I can send you

1 an email after.

2 DR. PARTIN: Great, thank you.

3 DR. NEEL: Thank you.

4 DR. PARTIN: Therapy Services.

5 MS. ENNIS: Good afternoon, I think we
6 are now.

7 DR. PARTIN: We are.

8 MS. ENNIS: I'll be very brief because
9 I know we're running over. I've missed the last few
10 meetings. We don't have any recommendations further
11 today, but I wanted to kind of bring the MAC up to date on
12 things that we've been working on. The big one was the
13 EPSDT transition that got put on hold. And, then, there
14 was concern from providers who had actually followed the
15 rules, gotten their Medicaid numbers, were billing through
16 regular therapy codes, and were getting reimbursed less
17 than the folks who didn't follow the rules and were now
18 still able to bill through EPSDT and get a higher
19 reimbursement.

20 So, we did have a letter to go out
21 soon after our last meeting, which was on the 6th of July.
22 I think the letter went out the 9th saying that all
23 providers could continue billing that EPSDT code and go
24 through the higher reimbursement as we're working on how
25 that whole program is going to shift.

1 So, at this point, we're managing
2 things through the TAC and trying to get information back
3 out to our providers. But if we have other concerns that
4 we need recommendations, we'll bring them forward in two
5 months.

6 DR. PARTIN: Thank you very much.

7 MR. WRIGHT: I'm sorry, I didn't --
8 what agency do you represent?

9 MS. ENNIS: Therapy Services.

10 MR. WRIGHT: And where are you at
11 specifically?

12 MS. ENNIS: I'm actually in KIPDA.
13 I'm in Louisville.

14 MR. WRIGHT: KIPDA Louisville?

15 MS. ENNIS: Although, we cover the
16 whole state.

17 MR. WRIGHT: Okay, good.

18 DR. PARTIN: Okay. So, we need
19 approval of all the recommendations that have been, both
20 from the TACs and from the MAC. If somebody would like to
21 make a motion to approve those.

22 MS. BRANHAM: I'll make a motion.

23 DR. PARTIN: Okay, Sharon.

24 MS. ANGELUCCI: I'll second it.

25 DR. PARTIN: Okay, thank you. Any

1 discussion? All in favor, say aye. Any opposed? So
2 moved. Thank you. Barbara, I will get the
3 recommendations from the MAC written up for you. I'll
4 probably get those to you by Sunday night or Monday
5 morning. Will that be okay?

6 MS. EPPERSON: Yeah, that's fine.
7 Because we meet I think it's Monday or Tuesday ---

8 DR. PARTIN: Okay.

9 MS. EPPERSON: --- to distribute
10 those. Thank you.

11 DR. PARTIN: Thank you. And, then,
12 under New Business, we had a question. With the Aetna
13 acquisition of Humana, how will that affect Humana
14 CareSource; or will it? Is there anybody here from
15 Humana?

16 MR. CARLE: You're going to have to
17 add Anthem to that, too, because Anthem is trying to buy
18 CIGNA.

19 DR. PARTIN: I just heard that this
20 morning.

21 MR. CARLE: Now there are three.

22 DR. PARTIN: Is there anybody here
23 from Humana?

24 AUDIENCE: I'm here from Humana
25 CareSource, but business as usual (inaudible).

1 DR. PARTIN: Okay. So, you're going
2 to continue to be Humana CareSource? You're not going to
3 be turned into Coventry?

4 AUDIENCE: (No audible response).

5 DR. PARTIN: Did you have a comment?

6 UNIDENTIFIED SPEAKER: Just to let you
7 guys know ---

8 DR. PARTIN: Come up to the table.

9 UNIDENTIFIED SPEAKER: Thank you. I'm
10 with Aetna. And right now is business as usual while
11 we're moving forward. Anything that you guys know that
12 has been out on the media is all that we know at this
13 point in time. So, it's at a very, very high level at
14 this point. And if you have any questions that you'd like
15 answered specifically, I can escalate those. But at this
16 time, what you guys know is what we know as well.

17 DR. PARTIN: Okay. Thank you very
18 much. Anything else that members would like to bring
19 forward?

20 MS. WHITTAKER: I have a comment. I'm
21 the new kid on the block. As far as transportation with
22 Medicaid, is there ever a report on the numbers on that?
23 I know in my area, one of our providers -- I know the
24 services has increased a third because of the new folks
25 that are eligible to ride on GRITS. So, do we ever get a

1 report in this meeting about those numbers?

2 COMMISSIONER LEE: Would you just like
3 a report on the number of individuals who access those
4 services, the non-emergency transportation services? We
5 do have reports because our non-emergency transportation
6 program, the Department contracts with the Office of
7 Transportation Delivery in the Transportation Cabinet; and
8 they administer brokers. They have brokers throughout the
9 state. And we do have routine reports. Some of them do
10 contain personal health information. So, we could kind of
11 modify some of those reports and you could see how many
12 trips are in each region if that would help.

13 MS. WHITTAKER: That's what I'd like
14 to see. Thank you.

15 DR. NEEL: You know, that has
16 something to do with overutilization of ERs and Urgent
17 Cares and that sort of thing, too. Because have many --
18 for example, children become sick during the day and need
19 to be seen and they don't have time to get the GRITS or
20 the other buses. And, so, the only way we can get them in
21 is pay for a cab to bring them in. Are there other ways
22 that we can help that? Because I think it's bigger than
23 we know.

24 COMMISSIONER LEE: So, the
25 non-emergency transportation program, we have brokers in

1 every region. When individuals need those services, they
2 need to call 72 hours in advance unless it's an emergency.
3 There are provisions for emergency. If you haven't
4 reviewed the information on our website related to
5 non-emergency transportation, I can send that out so you
6 can review it and look; because there are some exceptions
7 to rules.

8 For example, an individual is not
9 eligible to access non-emergency transportation services
10 if they have a vehicle in the household. So, if they do
11 have a vehicle and it's not operating, they would have to
12 provide some sort of documentation showing that the
13 automobile is not operable. Or if it's used during -- for
14 example, if there is a couple and one of the spouses may
15 use the car for work purposes during the day, then, they
16 can also get a note saying that that car is used for work
17 and not available during the day for the other spouse; and
18 they can get transportation. But I think that that
19 information related to the non-emergency transportation
20 would be really good for you to look at and kind of work
21 through that -- the program.

22 DR. NEEL: Thank you.

23 MR. CARLE: Beth, I think this is a
24 tremendous topic for an upcoming meeting because if we
25 truly want to transform healthcare, part of the reason

1 with hospital readmissions is that these patients that are
2 being discharged from the hospital can't get back to their
3 primary care physician or they can't get to the pharmacy.
4 And I know the state is working on that, but we need to
5 look into this further. So, I'm really glad the question
6 was brought up because it's a tremendous expense. I'd
7 like to know how the brokers are actually selected as
8 well.

9 COMMISSIONER LEE: The brokers are
10 selected through an RFP process ---

11 MR. CARLE: Okay.

12 COMMISSIONER LEE: --- and through an
13 active procurement. And non-emergency transportation does
14 not include transportation to the pharmacy. But I would
15 be more than happy to provide an overview of the
16 non-emergency transportation program and some numbers at
17 the next meeting if you would like.

18 MR. CARLE: That's great.

19 DR. PARTIN: Would you also include
20 for the emergency transportation as well?

21 COMMISSIONER LEE: Yes, we can include
22 some emergency. So, if you want at the next MAC meeting
23 to just give an overview of all transportation services in
24 the Department and how they're administered.

25 DR. PARTIN: Yes, thank you.

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MR. CARLE: Thank you.

DR. NEEL: Chris, I'm sure the hospitals are seeing the -- now that many primary care docs are not going to the hospitals, their patients are being seen by hospitalists. And, then, they're going home, and they're trying to get them followed up by their doctor. They didn't know they'd been in the hospital. It's a huge thing that's out there right now. And that's leading to readmissions because people are not getting back in for care.

MR. CARLE: Exactly.

DR. NEEL: We've got to work on that.

DR. PARTIN: Something else with the transportation, -- and I don't know if this is a reg or not -- but I got one the other day; and it said that I had to complete the form; that I couldn't use any assistive personnel to complete the form. And that was a new thing for me, but it was actually written on there on the instructions. And it seems to me that with all the paperwork that I have to fill out, somebody else could answer the questions; then, I could review it and sign it.

COMMISSIONER LEE: Was it to confirm that the individual was in your office or had an appointment?

DR. PARTIN: No, it was to request

1 transportation.

2 COMMISSIONER LEE: We'll look into
3 that, and we'll make sure that we provide information
4 related to the entire process at the next MAC.

5 DR. PARTIN: Okay, great. Thank you.
6 I guess that concludes the meeting. I would like to
7 comment that, Commissioner Lee, you have been very
8 helpful; and your staff has been just very forthcoming.
9 And the whole tenor of the Department has seemed to
10 change, and we really appreciate that. Thank you.

11 COMMISSIONER LEE: You're very
12 welcome. Would somebody like to make a motion to adjourn?

13 MS. WHITTAKER: I so move.

14 DR. NEEL: Second.

15 DR. PARTIN: All in favor.

16 (END OF MEETING)

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STATE OF KENTUCKY

COUNTY OF FRANKLIN

I, Rita Susan Moore, a notary public in and for the state and county aforesaid, do hereby certify that the foregoing one hundred fifteen pages are a true, correct and complete transcript of the above-styled meeting taken at the time and place set out in the caption hereof; that said meeting was taken down by me in shorthand and afterwards transcribed by me; and that the appearances were as set out in the caption hereof.

Given under my hand as notary public aforesaid, this the 5th day of August, 2015.

Notary Public
State of Kentucky at Large

My commission expires January 8, 2016.