

**CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE**

March 27, 2014
12:30 P.M.
Room 111 Capitol Annex
Frankfort, Kentucky

MEETING

APPEARANCES

Elizabeth Partin
CHAIR

Donald Neel
Sharon Branham
Susanne Watkins
Peggy Roark
Jonathan Van Lahr
Richard Foley
Chris Carle
Susie Riley
Karen Angelucci
COUNCIL MEMBERS PRESENT

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1 CHAIR PARTIN: I'd like to call the
2 meeting to order. If somebody could make a motion to
3 approve the minutes.

4 MR. VAN LAHR: So moved.

5 DR. NEEL: I'll second.

6 CHAIR PARTIN: So moved. All in
7 favor, say aye. Opposed? So moved.

8 We have some issues under Old
9 Business. The first one is Psych/Mental Health TAC
10 recommendations and those were voted on to move forward
11 and a request for a response from the Department for
12 Medicaid Services at our last meeting.

13 And I understand that a response
14 is in the works. Is that correct?

15 MS. ERIN HOPIN: Yes.

16 CHAIR PARTIN: When can we expect
17 to have that, do you think?

18 MS. HOPIN: It will be definitely
19 before the next MAC meeting, hopefully sooner.

20 CHAIR PARTIN: Thank you. So, we
21 will expect that, then, so we can review it before our
22 next meeting.

23 The next item is the issue of the
24 optometry frame kits, Avesis and CPT codes. Susanne.

25 DR. WATKINS: Yes. Bringing back

1 up what we had talked about before with Avesis here, one
2 of the things that I did want to bring up, when Avesis
3 was here, I brought up to them that it was taking
4 extensive time for us to get back our glasses through
5 Avesis.

6 And they had asked me if I was not
7 filing those online in order to get them back and was I
8 not capable of doing such. And I knew we had addressed
9 that before as far as we had tried to file them online
10 and wasn't able to.

11 So, I went back the very day after
12 and asked my insurance filing person to try that once
13 again. She was not able to get it to go online. We
14 contacted the lab personally. They said, no, it was not
15 up and running at that point yet and they would let us
16 know when it was up and running. So, we were trying as
17 best we could.

18 It is now up and running now. I
19 did verify that again this morning that we have been
20 able to get that to go online within the last month, but
21 it was not so when we were here in January, but we are
22 getting a week's turnaround on the glasses now.

23 We are still having some problems
24 with the frame kit with the children coming in. Just as
25 an example, I had a child come in, an 18-year-old, still

1 eligible for glasses weighing 350 pounds. There was
2 nothing in the kit that she could wear that wasn't wide
3 enough for her head because she's not just of average
4 size.

5 When you go to put on a glasses
6 frame, if it's too small and it squeezes the side of
7 your head, not only are you providing tension on the
8 side of the head but that's forcing that frame forward
9 which means the prescription is farther from your eyes.
10 It's falling down the nose. That's not acceptable as
11 far as trying to wear a prescription.

12 This patient was legally blind
13 without her glasses. So, this is something she was
14 having to wear daily to do her schoolwork. She told me
15 she was dependent enough on her glasses that she often
16 showered with her glasses on in order to be able to see
17 well enough to take care of herself.

18 So, there are situations where
19 they are eligible for glasses up until they turn 21.
20 So, they need to have frames that they can choose from
21 that will fit them properly.

22 We were talking about the children
23 being stigmatized and not being able to choose frames
24 that their friends would approve of. We have had
25 instances already where children have looked at the kit

1 and just told their parents and told us, I will not wear
2 these and walk out without a pair of glasses. These are
3 children that cannot see to do their schoolwork without
4 their glasses and they are absolutely refusing to fill
5 their prescription because of the selection that they
6 are given.

7 This is reflecting on the doctors
8 because they know in the past we've had a broader
9 selection. And when they come in and they see the
10 little bit that we have to offer them, then, they feel
11 like that as a doctor, I'm not offering them the quality
12 or the variety that they have been used to receiving and
13 we have to let them know what their plan will cover and
14 that's not our fault.

15 We've had several instances where
16 new adults on the program - these are people that are
17 over 21 - that have adamantly told us that their MCO
18 told them that they would cover glasses for everyone,
19 and it's been up to us to tell them that, no, that's not
20 correct, that the plan only covers up until you turn 21
21 and then it no longer covers glasses.

22 And we've been told that we don't
23 know what we're doing as Medicaid providers because of
24 the fact that they are claiming the information they're
25 getting from their MCO is different. And, so, there are

1 some problems with the program there.

2 We have already testified on the
3 new regulations and brought up the points of the
4 problems that we have with the new regulations. Some of
5 them that I discussed at the last meeting I'll bring
6 back up to you again.

7 We referred to the fact that in
8 the past, the benefit has always been that there is to
9 be one eye exam per provider per year. Now the
10 particular regulation says one eye exam per year, and
11 the Impact Analysis brings up the fact that that has
12 been changed and it was intentionally changed.

13 Well, this decreases the benefit
14 to the person, the Medicaid eligible because of the fact
15 that say if I feel it medically necessary to send that
16 patient on to another physician and they also do a
17 routine eye exam, or if that patient wants a second
18 opinion, say if they were told their four-year-old needs
19 glasses and they don't believe it and they want to go to
20 another provider and get another eye exam, that's not
21 going to be covered.

22 If they come back within a year,
23 say if they've had a growth spurt and now their
24 prescription has changed, well, it states in the regs
25 that they will cover a pair of glasses for a change in

1 prescription. But if they're not going to cover the eye
2 exam to determine what that prescription is, how do you
3 get the new prescription in order to verify that the
4 patient needs a new pair of glasses? And these are
5 things that are not properly addressed in the
6 regulation.

7 In the previous regulation that we
8 had, there was an optometric schedule. Let me get the
9 correct wording of it here. We're now given a fee
10 schedule, but there was previously a manual that was
11 used to define these limits that were to be placed on
12 people.

13 When it makes reference to this
14 fee schedule, and, once again, in the Impact Analysis,
15 it's stated that now we have this fee schedule to
16 replace the vision manual. Well, a fee schedule that
17 lists nothing but codes and tells you the amount that
18 that code is going to be paid for does not give you any
19 explanation of how often that code is to be reimbursed
20 or saying that it is per provider per year.

21 And I will tell you right now, if
22 you go up on any of the websites and look to see if that
23 person is eligible for an eye exam, it does not tell you
24 whether they've had an eye exam in the last year or not.
25 So, you have no way of knowing that if they are eligible

1 for an exam if you do one today.

2 So, yes, if they saw you last
3 year, you have your record, but that's not telling you
4 that the patient hasn't seen someone else in the
5 meantime and that exam being reimbursed for an eye exam.
6 So, when you see that patient, you have no way of
7 knowing that that exam is going to be covered.

8 One of the main problems that
9 we're having with the new MCOs lies with DentaQuest
10 which is the vision provider that Anthem has chosen.
11 And just this morning while I was at the KOA office,
12 there were four different doctors that called
13 complaining and questioning why they couldn't get
14 credentialed with DentaQuest, myself being one of them.

15 I have been trying since November
16 to get on the panel for DentaQuest. We have had other
17 providers that were first told that the panel was full
18 which that goes against any willing provider law in the
19 State of Kentucky.

20 Once we got through that issue
21 that they said, yes, these people could apply, then, we
22 are being told time and time again, myself included, we
23 are considering your credentialing. We need another
24 paper to finish your credentialing. Your credentialing
25 is going before a committee. We will get back to you in

1 six to eight weeks.

2 And in the meantime, I had a
3 patient come in that told us that they were going to be
4 turning 21 in two weeks. I have no guarantee that I'm
5 going to be able to provide them with vision services
6 because they had Anthem. So, we called for them to
7 DentaQuest to see what was the closest provider that
8 they could go to to get their glasses, and we had to
9 refer them to a doctor that was an hour away from us in
10 order for them to get their services.

11 We are not having this problem
12 with any of the other MCO's signing up their doctors.
13 The credentialing shouldn't in no way take months and
14 months to be completed.

15 That's all I have right now.

16 CHAIR PARTIN: It sounds like -
17 and maybe I'm not correct - but it sounds like maybe we
18 were talking about more than just the frame kits, Avesis
19 and the CPT codes. Some of these were new things that
20 you were bringing up, the issues?

21 DR. WATKINS: Some of them were,
22 yes.

23 CHAIR PARTIN: What we will need
24 to do is have those things made as recommendations so
25 that the MAC can approve those or acknowledge those and

1 then ask for a response from the Department for Medicaid
2 Services.

3 DR. WATKINS: Okay. And am I
4 still under the understanding that a recommendation must
5 come from the TAC? Is that correct?

6 CHAIR PARTIN: Yes. I assumed
7 that you were giving a report for the TAC.

8 DR. WATKINS: At this time, the
9 TAC has not been able to meet because, from our
10 understanding, now TAC meetings must be listed as public
11 meetings, must have an announcement of when they're
12 going to happen to the public and the meeting set up
13 with Medicaid and the committee and it be open to the
14 public and set up in that fashion.

15 CHAIR PARTIN: I think, though,
16 since the TAC has not been able to meet and you are the
17 representative on the MAC for optometry, if we have your
18 recommendations, then, we can vote on those and then
19 move it forward that way.

20 DR. WATKINS: Okay.

21 CHAIR PARTIN: I just wanted to
22 clarify that for everybody so that we can get a response
23 to your comments.

24 DR. WATKINS: Okay. Thank you.

25 CHAIR PARTIN: The next issue is

1 the APRN locum tenens. And as you all know, we received
2 a letter from Commissioner Kissner regarding this issue.
3 I know I was very pleased and I know other APRNs were
4 every pleased that the Department has determined that
5 APRNs may serve in a locum tenens role.

6 However, there is one small
7 problem and I have sent a letter to the Commissioner
8 addressing this, and that is that it was specified in
9 the letter that the APRN who is serving as a locum
10 tenens must be credentialed with Medicaid before they
11 can serve in that role.

12 That's a problem because it takes
13 at least 120 days to get credentialed. And practices
14 that use locum tenens may not know that far in advance
15 that they're going to require that service, and,
16 therefore, it would be impossible to get that person
17 credentialed prior to them serving in that role and
18 being able to see the patients.

19 We see this as an access-to-care
20 issue. It's important for the patients to be able to
21 have continuity in their care, not for the practice to
22 shut down if the APRN provider has to be absent for a
23 period of time.

24 And, so, we would ask that the
25 APRN locum tenens be afforded the same opportunity that

1 physicians have which is to use a Q modifier for the
2 billing and, therefore, the billing would go under the
3 APRN who is credentialed with Medicaid and who the locum
4 tenens are substituting for.

5 And I did send that letter and I
6 believe I sent a copy to this committee. So, I would
7 ask that we vote to move that recommendation forward so
8 that we can get a response from the Commissioner on
9 that, or perhaps the Commissioner already has a
10 response.

11 COMMISSIONER KISSNER: No.

12 CHAIR PARTIN: No? Okay. Wishful
13 thinking.

14 DR. NEEL: So moved.

15 DR. RILEY: Second.

16 CHAIR PARTIN: All in favor.

17 Opposed. So moved. Thank you.

18 The next issue is the Intellectual
19 and Developmental Disabilities TAC at the last meeting
20 brought up problems - and, I'm sorry, I'm not familiar
21 with what this is, so, I'm just going to read what I've
22 written - problems with the SCL2 implementation and the
23 Michelle P. Waiver. And Barry brought those up. Is he
24 here today?

25 MS. HUGHES: No. He's out of

1 state. in a meeting.

2 CHAIR PARTIN: Do we have anybody
3 here who can speak to that issue?

4 MS. PATTY DEMPSEY: I can talk
5 about it.

6 CHAIR PARTIN: Okay. Come
7 forward, please.

8 MS. DEMPSEY: Thank you very much
9 for including it on the agenda today.

10 My name is Patty Dempsey and I
11 represent the ARC on the TAC group, the IDD TAC group.
12 And what the issue was, and I appreciate again you all
13 putting that on the agenda for today, but the issue that
14 we had at the time with that TAC group was that there
15 was not an implementation date for the SCL2 Waiver
16 Program. And, so, there were concerns about when that
17 was going to be implemented and the lapse of services
18 between the old SCL Waiver or SCL and the SCL2 Waiver.

19 So, that was a lot of the concern
20 that we had at the time. And since that time, the SCL2
21 Waiver has been implemented, is being implemented now as
22 of January 1st.

23 There are some issues on that that
24 I can talk about later in our report.

25 CHAIR PARTIN: That would be good.

1 So, this problem is resolved?

2 MS. DEMPSEY: Actually, SCL, one
3 is. One isn't. The SCL2 Waiver has started and there
4 are some issues that family members have about that;
5 but, yes, that was one of the big problems of when that
6 was going to start.

7 And, then, the other thing was the
8 Michelle P. Waiver, was there going to be a waiting list
9 because the thought was that the Michelle P. Waiver
10 would reach its cap at the end of December. And if it
11 did reach its cap at the end of December, which I think
12 it probably did, was there going to be a waiting list.
13 So, that's kind of still unresolved if there is a
14 waiting list. So, that was the other problem.

15 MS. BRANHAM: Just for
16 clarification purposes, what is the SCL?

17 MS. DEMPSEY: I'm sorry. It's
18 called the Supports for Community Living Waiver. And,
19 so, there is a Supports for Community Living Waiver.
20 And through the Department for Behavioral Health and the
21 Department for Medicaid Services, there's now a Supports
22 for Community Living Waiver 2 that has some additional
23 community services. People will go from the original,
24 as their birth date approaches, they will be assessed
25 for the SCL2 Waiver. So, that has started.

1 The other problem with that was
2 people that are in the community and getting services in
3 the community, was that going to affect their budgets
4 that they have? Was there going to be a delay, and were
5 people that are out there taking care of family members
6 not going to be able to have funding? They didn't want
7 a break in services for the funding.

8 CHAIR PARTIN: So, that issue is
9 resolved and we're still waiting to find out if there's
10 a waiting list for the Michelle P. Waiver?

11 MS. DEMPSEY: Yes.

12 CHAIR PARTIN: So, what we are
13 trying to do with our Old Business is carry over issues
14 that the committee has voted on and ask for a response,
15 but we have not received a response yet. And, so, we'll
16 put that on the next agenda.

17 MS. DEMPSEY: Okay. Thank you.

18 CHAIR PARTIN: Home Health, extend
19 the waiver for sixty days.

20 MS. BRANHAM: Yes. This refers to
21 most likely the Waiver Programs that involve EPSDT and
22 those kinds of things that are serving kids with
23 multiple problems.

24 We are still on opposite sides of
25 the line drawn in the sand on this one. At our TAC

1 meeting last week, we asked the MCO's that were present
2 if there was any way that we could meet and come to some
3 kind of agreement to save costs for agencies as well as
4 their prior authorization crew.

5 And the continuing rebuttal is it
6 has to be medically necessary. And, yes, we understand
7 that, but we also know that there is no set method among
8 providers around the state that relate to one patient
9 may be approved for six months, one patient may be
10 approved for sixty days.

11 So, there's really nothing fo us
12 to use as a standard or a guide other than medically
13 necessary, and we wouldn't be asking for authorization
14 if it wasn't medically necessary or they didn't qualify
15 for the service.

16 I have been approached with maybe
17 a possibility that we may be able to gather the data,
18 scrub this data out from the State to see what diagnoses
19 that they are approving for longer than thirty days or
20 two weeks and then present that information to them.
21 And, then, maybe we could get the Medical Directors
22 involved along with the Cabinet's Medical Director and
23 maybe get some kind of relief on this. So, that's where
24 we currently stand on this.

25 CHAIR PARTIN: So, still pending?

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MS. BRANHAM: Yes.

CHAIR PARTIN: Okay. Thank you.
At the last meeting, the Hospital TAC brought up an issue about payments to in-state hospitals versus out-of-state hospitals and a transitioning period for the phase-in of the DRG base rates. Would you like to speak to that?

MR. CARLE: Yes. We've got a lot of things on the agenda. So, we've got the representative here from the TAC.

I would like to say, though, in the past, we've always enjoyed a very collaborative relationship, and recently we have been at somewhat of a disconnect between the two. So, we would like to resolve those issues.

And we've had some movement on the federal side that have changed some things that Mr. Herde will go into a little bit of detail with regards to the DRG base rates and how those can be phased in.

CHAIR PARTIN: Okay. So, we'll have specific----

MR. CARLE: Because we've got such a long agenda, he's got specific recommendations that we will do under the TAC recommendations.

CHAIR PARTIN: Great. And, then,

1 the last thing under Old Business was a recommendation
2 from the MAC for standard quality measure for the MCO's,
3 and it was suggested that obesity and smoking were two
4 issues that we could cover.

5 The quality measures that we were
6 supposed to suggest were to be different from the ones
7 that are currently being measured by the MCO's, and
8 right now it's antidepressant medication management,
9 reducing emergency room utilization, dental care rates
10 for children with special care needs, reducing
11 inappropriate antibiotic use, and ADHD medication for
12 children.

13 So, the smoking and the obesity
14 are not currently quality measures that are being
15 monitored, but the floor is open for any suggestions
16 from this committee on quality measures that you would
17 like us to recommend for the MCO's to monitor.

18 MS. BRANHAM: I wouldn't mind
19 seeing readmission being addressed.

20 CHAIR PARTIN: Weren't we supposed
21 to just pick one?

22 COMMISSIONER KISSNER: One.

23 CHAIR PARTIN: One measure, right.
24 So, we have to pick one.

25 MS. BRANHAM: How about the ones

1 that you just read?

2 CHAIR PARTIN: The list that I
3 read are the ones that are currently being monitored.
4 So, we have to pick something different. At the last
5 meeting, I had just suggested obesity or smoking because
6 those are major problems.

7 COMMISSIONER KISSNER: It doesn't
8 have to be different. It's just with the way it works
9 now - and I'll reiterate this for everybody so you can
10 understand - IPRO goes to the MCO's and says, come up
11 with two items that you're going to monitor.

12 Up until this point, we've let
13 them pick their own. So, that list that you read, ER,
14 anti-psychotic drugs, that's what they--and some of them
15 do the same thing. Like ER utilization, two of the
16 MCO's actually report on that statistic.

17 What I've asked Dr. Langefeld and
18 you guys to do is going into 2015 when we give them the
19 new Quality Improvement Plan, we're going to say you get
20 to pick one and we're giving you one so that we have all
21 five MCO's reporting on the same because right now they
22 can report on different things. It's their choice to
23 drive quality improvements in their own health plan.

24 So, they all chose different
25 things and we're trying to create, which is okay for the

1 first couple of years, but we want to create a common
2 review. So, one of the two. They get to pick two.
3 We're going to give them one and they get to pick one.

4 So, it could be one of the ones
5 that's already mentioned or it could be something new,
6 but a quality measure. That's what we're looking for.

7 DR. RILEY: Since obesity has such
8 an impact on several other health issues, I would
9 suggest obesity from our group.

10 CHAIR PARTIN: Anybody else have
11 any other comments?

12 MS. ROARK: I'm going to agree
13 with obesity because I don't like either one of them but
14 I'm thinking our small children are having obesity
15 problems at young ages leading to diabetes, high
16 cholesterol. So, I guess I'm going to say obesity.

17 MR. CARLE: It might be helpful if
18 we send that entire list out, although I agree with
19 what's been said on obesity, send the list out and let
20 us rank them and maybe get back to them as soon as
21 possible on that. Send a list that we have to choose
22 from because what the Commissioner just said, it's
23 somewhat limited moving forward.

24 So, I think we need time to take a
25 look at it and just make a real good decision and then

1 send all that information with a certain timetable and
2 then get back to them on that.

3 CHAIR PARTIN: Okay.

4 MS. BRANHAM: I will selcond that.

5 CHAIR PARTIN: What is our
6 deadline, Commissioner, for submitting this?

7 COMMISSIONER KISSNER: We just
8 have to have it by year end because we have to put it in
9 their 2015 IPRO plan.

10 CHAIR PARTIN: So, there is really
11 no list. The list is ours to make.

12 DR. LANGEFELD: Can I make a
13 comment?

14 CHAIR PARTIN: Yes, sir.

15 DR. LANGEFELD: The Governor has
16 announced a Health Initiative and he has identified
17 several targeted goals in that initiative.

18 And what I would suggest maybe is
19 we have you think about everybody getting on the same
20 page, which is what we talked about last time. Obesity
21 is, by the way, one of the areas that have been
22 identified in that. So, I think that's a good thought.

23 If you'd like some additional
24 information or data in order to think through it, we
25 will be glad to do that as well. Obesity is probably an

1 interesting choice because historically in claims data,
2 it's difficult to get at. If you have clinical records,
3 you can calculate BMI, etcetera; but typically in claims
4 data, the coding for diagnosis is not consistently used.
5 And we would like it to be used more and we would like
6 the information to capture BMI's more consistently,
7 etcetera.

8 So, I think that would be a very
9 positive direction and certainly consistent at a state
10 level.

11 MR. CARLE: Well, I guess that's
12 why I brought it up. And I appreciate your
13 clarification, but there are so many ways to measure it
14 other than just BMI. There are multiple comorbidities
15 that are associated with obesity.

16 So, how are they actually going to
17 look at it? Is it just going to be an indicator of BMI
18 greater than 30, you're considered obese and they're
19 going to give us the numbers? So, we need a little bit
20 more detail as to how we would actually evaluate a
21 quality indicator and a managed care plan related to
22 obesity.

23 DR. LANGEFELD: Excellent
24 question. And I think that's the type of clarification
25 we can have a discussion about and we can maybe give

1 some feedback around.

2 MS. BRANHAM: So, will you provide
3 us with the Governor's initiatives, then?

4 DR. LANGEFELD: Yes, absolutely.
5 It's on the website at Kyhealthnow is one way but we'll
6 certainly give you a copy of it as well.

7 CHAIR PARTIN: If you could just
8 have Sharley email us at least the link to that. And,
9 then, if you have any other information about how to do
10 quality measures around obesity, some ideas about that,
11 that would be really helpful to send out to the
12 committee as well.

13 MS. BRANHAM: Well, they'll never
14 be the same information.

15 DR. NEEL: One of the things he
16 says about coding is true because I know pediatricians
17 are advised not to code as obesity but code as risk of
18 overweight, for example, trying to be better in the way
19 we don't say kids are fat or they're at obese. They're
20 at risk of overweight. Certainly with Kentucky being
21 almost at the top of the list on obesity, but it's also
22 one of the most difficult things to examine.

23 DR. LANGEFELD: Why don't I
24 provide you some feedback and flesh that out a little
25 bit, if you'd like.

1 CHAIR PARTIN: That would be very
2 helpful. I know that there's a code for BMI that you
3 can put in for that and, then, there's also a code for
4 counseling for nutrition. So, those might be two ideas
5 to kind of try to capture that, but that would be very
6 helpful. Thank you.

7 Commissioner Kissner.

8 COMMISSIONER KISSNER: I've got
9 good news and good news. The good news is that you will
10 still be getting binders, but everything in this binder
11 will be posted on our website by April 27th, by one
12 month from today. And going forward, we'll post--we've
13 got to reconfigure the site. We've got to set it up and
14 we've got to convert everything to a PDF file. It's
15 just the mechanics of doing it.

16 So, it will probably take about
17 thirty days from the date of the MAC to get it all
18 posted, but that's our goal. So, you guys have asked
19 for that and we'll get that to you.

20 MR. VAN LAHR: Any possibility,
21 Commissioner, of having this posted prior to the
22 meetings?

23 COMMISSIONER KISSNER: That's
24 tough. We're adding stuff yesterday, today. We could
25 theoretically create a cutoff and say one month prior to

1 the MAC, we stop loading stuff in the binder and then we
2 get it on, but we need about thirty days.

3 MS. BRANHAM: But you're still
4 giving us this at every meeting, right?

5 COMMISSIONER KISSNER: Yes.

6 MS. BRANHAM: It's just going to
7 be made public on the website.

8 COMMISSIONER KISSNER: Everything
9 we give you, I kind of would rather do that; but if you
10 guys want me to, then, if that's what you want. I just
11 have to have a cutoff date that's thirty days prior to
12 posting, okay? That's all I'm saying. I need thirty
13 days.

14 MR. CARLE: Anything that happens
15 in between there, you could bring with you.

16 COMMISSIONER KISSNER: Yes, and it
17 just wouldn't get posted.

18 MR. CARLE: Correct, until a later
19 date.

20 COMMISSIONER KISSNER: Right.

21 MR. CARLE: Would that be okay
22 with you?

23 MR. VAN LAHR: Yes. I just have
24 this collection of binders at my house and my wife keeps
25 asking me what I'm going to do with these binders and

1 I'm just trying to avoid that and save some trees maybe
2 at the same time.

3 COMMISSIONER KISSNER: Okay. So,
4 I'm not going to go through all the sections. I do want
5 to point out a couple of really important things.

6 We had a number of communications
7 from CMS. If you go to the one that's dated--it's the
8 last one in the first section which is dated March 25th,
9 this is a pretty important letter. Let me give you some
10 background.

11 The feds are paying 100% of ACA
12 expansion for three years. That's the deal. That's the
13 Affordable Care Act. They don't want to pay too much.
14 It's an undefined group, right? There's no risk.
15 There's no risk that can be identified. It's a brand
16 new population that's never had insurance before, right?
17 So, how do you set the rate?

18 What we did was we used our
19 actuaries and we set the rates based on our current rate
20 structures. And they have since come back and said in
21 this letter, we will move ahead with our rate and
22 contract approvals allowing the State to continue use of
23 its current processes for 2014 but only if the State
24 agrees to implement a risk mitigation strategy for the
25 rates set for your newly eligible population. Without

1 such arrangement, CMS will be unable to approve the 2014
2 capitation rates.

3 CMS recommends that we implement
4 either a symmetrical risk corridor, protecting the
5 financial interest of both the payor and the MCO, the
6 payor being the feds, or a medical loss ratio which
7 essentially does the same thing.

8 So, let me give you an example.
9 In individual insurance in the State of Kentucky, the
10 loss ratio can be no less than 80%. So, you probably
11 read in the paper where Humana wrote checks to the
12 individual participants and actually refunded money,
13 millions of dollars in the State of Kentucky.

14 If their loss ratio comes in at
15 79%, they have to give back that 1%. They have to use
16 at least 80% of it on claims. Now, if it comes in at
17 85%, they don't ask the individual people for more money
18 because they say, hey, we spent more than we thought.
19 So, that loss ratio is sort of a one-way door. If it's
20 too good, you've got to refund to the participants; but
21 if it's high, well, better luck next time.

22 So, the symmetrical risk corridor
23 is where you pick a goal and they say, okay, so, if the
24 claims are worse than it's expected, we will give you
25 more money, managed care companies. We'll pay you more.

1 And, conversely, if the risk is better, you have to pay
2 back some of your capitation. That's what the feds are
3 asking for, some way to share if the experience--and
4 they believe that the nature of insurance tends to be
5 conservative. And, so, the chances are you're probably
6 over-pricing the ACA expansion members rather than
7 under-pricing.

8 So, they believe it's in their
9 best interest and especially since they're 100% on the
10 hook for the whole premium for expansion members to get
11 some opportunity to get a refund if the claims come in
12 less than anticipated. So, that's a major deal.

13 Now, luckily, we have in our
14 contracts that the rates with the MCO's, that the rates
15 have to be approved by CMS. So, the MCO's now know that
16 - I think this is probably the first they've officially
17 heard of this - but they now know that we've got to get
18 this worked out. CMS needs to approve our rates,
19 otherwise, there's no deal.

20 So, that's a requirement in our
21 contract. And obviously we don't want to risk the
22 federal funding being in any way diminished. So, we
23 want them to approve our rates. We need them to approve
24 our rates. So, that's kind of an important one.

25 We've submitted a number of things

1 to the feds. We had a lot of activity at year end and
2 now this is sort of a lot of cleanup activity where
3 we're responding to formal Requests for Information or
4 we're submitting new State Plan Amendments or things
5 like that.

6 We did have a few issues related
7 to some Corrective Action Plans which you have here
8 documented.

9 The reason this binder is so big
10 this month is because of the section that has all of the
11 providers, and you can see that Anthem has added
12 thousands and thousands, so has Humana, of providers
13 because they started really statewide on 1/1/14. So,
14 they in January and February have been loading in just
15 tons and tons of providers. So, this whole section here
16 is all brand new providers and they're all listed there
17 for you.

18 Now, one of the things I want you
19 to know that we're working on is my team took the
20 December adds, changes and deletes of providers, and we
21 audited it and we went on their system, went online, and
22 we went onto their website and we said, Dr. Smith, Dr.
23 Smith in the program, and we did this in February.

24 You told us in December this
25 doctor was terminated, so, they should not be there.

1 And you told us in December that this provider had been
2 added, so, they should be there sixty days later, right?
3 So, we audited that and have presented the preliminary--
4 is Lee here?

5 MS. HUGHES: No.

6 COMMISSIONER KISSNER: I know we
7 presented to the MCO's the preliminary findings and then
8 we're asking them to see if we've missed anything.

9 We also audited information like
10 is the name, address, phone number and everything
11 correct, and we found significant discrepancies.

12 We also learned a lot about the
13 websites and we've asked that question, like how do you
14 go through the website and how do you find a doctor; and
15 assuming you put on a member's shoes and you're trying
16 to find a cardiologist or you don't know how to spell
17 cardiology, so, you're trying to find a heart doctor or
18 you're trying to find a primary care doc, how do you
19 find a physician? How do you search? How many people
20 can you search? Can you put in your Zip Code and say
21 tell me who is around me?

22 So, they went through all of that
23 and they documented their experiences and they're
24 asking. So, what I've asked them to do is hook up our
25 projector to the Internet and bring the MCO's in to the

1 conference room and walk through the same exact step by
2 step that you did at your desks. Do it on the big
3 screen with them in the room and say, am I doing
4 something wrong? Am I not searching this correctly
5 because I'm trying to find Dr. Smith and I can't find
6 Dr. Smith in your system and there's a Dr. Neel in
7 Owensboro and I'm trying to find him and how do I find
8 him and how do I know that he's there? I know I spelled
9 his name right. How do I find him and what am I doing
10 wrong?

11 So, we're still in the process,
12 but ultimately this will end up being an audit that
13 we're able to present to you guys and say here's what we
14 found, and then if there's an error rate above 5% or
15 10%, we'll ask them for a corrective action to fix it.
16 We have not audited this giant list yet. This is a
17 pretty big list. We did just a sample of like 100 or so
18 providers for each MCO - 50 adds, 50 deletes, make sure
19 they're there.

20 IPRO, they did their Web-based
21 Provider Directory Validation Study. They're also
22 completing this month a couple of additional ones on
23 newborns and hospital re-admissions. Somebody mentioned
24 hospital re-admissions being an important thing.

25 We will have an IPRO analysis of

1 all the MCO's and what's happening in the state. These
2 are definitely worth homework assignments of reading
3 through what they say. These are professionally
4 presented and performed analyses of the data that we
5 have in the system and the MCO's and their performance.

6 The good news stories as always.
7 We had a few, just a couple of announcements to the
8 providers which are in here.

9 We have the new Member Handbook
10 which is in the second to last section. We printed
11 these up. They're available for all members and it has
12 a sample of the plan design and information there. This
13 is the one that's approved for member distribution. So,
14 it's written at a seventh grade reading level. That's
15 always a challenge, given healthcare, but we do our best
16 and run it through the flush test and all that and come
17 up with a result. Anyway, that's in there. That's
18 available for public consumption.

19 And, then, we have the closeout,
20 at the very end, some odds and ends. The 1115 Waiver
21 was the Passport Waiver for managed care that we've had
22 for fifteen years. The new one is 1915. So, the two
23 different sections of the codes is what that means. So,
24 1115 is a Waiver. 1115A is the Waiver that Passport
25 used.

1 So, we shut that down and now we
2 have a 1915 Waiver that all of the MCO's participate in.
3 So, we needed to close it out with the federal
4 government and that's what this Evaluation Design and
5 Final Report does is it goes through and it provides a
6 lot of information. Again, this is a professionally
7 prepared analysis of what happened and some of the
8 results. So, that's probably another worthwhile
9 homework assignment.

10 And then just some odds and ends
11 on the Pharmacy TAC that we changed on the fee-for-
12 service side with Magellan, some items that we met there
13 and approved those changes.

14 And, then, the last thing, the
15 very, very last page is a cheat sheet that you providers
16 will appreciate which is here's all the people to
17 contact from the President and CEO on down for all of
18 the managed care companies.

19 I do have a handout that I wanted
20 to share with you guys. So much of what we do in
21 Medicaid is predicated on the budget. We're right in
22 the middle of the budget.

23 So, let me tell you what's
24 happened. The Governor presented his budget. The House
25 reduced it and passed it. So, we have less money in

1 Medicaid and I'll explain how. Then the Senate passed
2 their version. They passed the exact same financial
3 consequences for Medicaid. I did not look at the rest
4 of the budget. So, don't ask me about pensions or
5 schools or prisons. I'm just laser-focused on Medicaid.

6 This is the wording. So, what was
7 different in the Senate version was the wording, and the
8 wording, what I handed out to you, is sort of important.

9 So, the first one is under the
10 Affordable Care Act, they state that the General
11 Assembly shall limit ACA's impact on the 2014-2016
12 State/Executive Branch Budget and future biennial
13 budgets as not to bind future General Assemblies. We're
14 sort of in agreement but can't bind us in the future.

15 There are no General Fund
16 appropriations for the Affordable Care Act.

17 The Governor is expressly
18 prohibited from expending any General Fund resources on
19 any expenditure directly or indirectly associated with
20 the Health Benefit Exchange.

21 And, then, I love notwithstanding.
22 Notwithstanding any statute or regulation to the
23 contrary, if the Medicaid funding schedule for the newly
24 eligible individuals - and they cite 42 U.S.C., Sections
25 1396d(y) (1). That is the actual FMAP section. That's

1 the federal participation, the 70/30, they pay 70, we
2 pay 30 or 100/0 in the case of expansion. If that is
3 modified to require any increase in state funding, all
4 Medicaid services and eligibility standards for those
5 services shall return to the levels of service and
6 eligibility standards as of 1/1/13.

7 So, they basically say if you
8 change the game on us where you're not picking up 100%
9 share, then, we don't want to play. Now, this is the
10 Senate version and there's a House version and they have
11 all sorts of words and stuff in theirs, too.

12 Go to the dollars which is the
13 last page because none of these--they have only passed
14 each representative House and Senate. This isn't the
15 budget. This is where we are right now as of today.
16 This is the most current information.

17 So, you can see the Governor's
18 recommendation. We have the General Benefits. We have
19 broken out into two areas. There's Medicaid Admin and
20 Medicaid Benefits. So, in the Admin, it's across the
21 board exactly the same. So, no real issues there other
22 than we have no additional employees to do anything, but
23 that's where we are. It's exactly what the Governor
24 presented.

25 When you get to the Benefits, you

1 can see that the Governor had set aside \$15.7 million of
2 tobacco funds to help pay for stuff, help pay for
3 Medicaid, and both the House and the Senate removed
4 that, and they also cut the General Fund by \$9.7
5 million. They reduced tobacco funds by \$15.7 million.
6 And this is all State funds.

7 And then they said Restricted
8 Funds is \$20 million and they increased the Restricted
9 Funds by \$20 million which they don't tell you how to do
10 that and don't give you any opportunity to do that.
11 That just means go find money. If you find it, you can
12 spend it.

13 Now, we looked for all the money
14 we could find when we did the budget. We don't have any
15 secret like pot of gold where we can go find \$20
16 million.

17 Examples would be like increasing
18 the provider tax which requires a law and all of that -
19 that would be tough to do - or recoupments, if the
20 Attorney General and the Office of Inspector General
21 find fraud going on and they recoup money, and you get
22 these in the newspaper, these big settlements for
23 millions of dollars, you know, more than we projected,
24 and we did project, we would assume, kind of we're
25 operating on the same basis we've been going in the past

1 few years. So, if something like that were to occur,
2 that's where you would find another \$20 million.

3 So, adding those together, we have
4 a significant shortfall. If we can't find the money, we
5 have a significant shortfall. We don't have a final
6 budget, but how does Medicaid make their budget work is
7 the question if it comes in and we have actually \$20
8 million less of state funds which is worth, it's like
9 \$80 to \$100 million of total funds because the feds are
10 70/30, 80/20 on KCHIP and other stuff. So, it's tough.

11 There's optional benefits. You
12 could adjust optional benefits which is like dental and
13 prescription drugs. You could raise taxes. You could
14 modify benefits. You could modify fee-for-service
15 reimbursements, but we'll have to come up with some
16 answer.

17 I'm just giving you the heads-up
18 as to where we are today and it's not what we had--I
19 purposely left off what we requested from the Governor
20 because I think at that point, that's sort of
21 irrelevant, right? I'm appointed by the Governor. So,
22 once he made his recommendations, I agree with those,
23 but this is from there to today, here's what's in this
24 building somewhere being discussed right now.

25 So, to answer your question, there

1 was an earlier question about Michelle P. The feds
2 approved 10,000 slots. We stopped at 10,022. We
3 stopped. And we have submitted, which is in the process
4 of getting approved - I signed it already - I think it's
5 at the Secretary's desk - an emergency regulation, an E
6 reg that creates a waiting list.

7 And, so, we have been holding them
8 in expectation of that because the feds have said, I
9 give you permission to have 10,000 slots. Now, you
10 could go over. They just don't fund it, and obviously
11 we can't afford 100% state funds to fund for something
12 that's currently 70% federal funds.

13 So, we have reached that. We did
14 apply in our budget for some additional slots. It's
15 accelerating. The number of people who apply for
16 Michelle P. has been growing every month forever since
17 we launched it. We will probably have waiting lists
18 like we do. I think everything now has a waiting list
19 with the exception of Model II vent-dependent people.
20 There's only about 50 or 60 people that are in that
21 program, and the Home- and Community-Based Services.

22 So, the feds in our State Plan
23 Amendment, it's the ceiling. They say here's what you
24 can spend your money on, but, then, we have to create
25 regs that allow us in the state to actually spend the

1 money on that. And we submit the SPA. It takes ninety
2 days. Sometimes it's six months, sometimes a year.
3 And, then, we have to submit a reg and do the reg
4 change. So, keeping those two things in sync when they
5 have different timings and periods is really a
6 challenge, but we did all of that for 1/1 with the new
7 Plan designs.

8 The other point of clarification
9 is SCL, Supports for Community Living, 1 and 2. They're
10 not two different Waivers. SCL1 is converting to SCL2,
11 and the SCL2 was modified. It had a bunch of changes in
12 it, and the changeover is on the person's renewal date
13 on their recert, recertification date. So, they go from
14 being in 1 to 2.

15 And, so, over a 12-month period,
16 it started January 1st, and by January of 2015, there
17 will be no more SCL1 and everybody will be transitioned
18 to SCL2. So, we're just in a period where we're
19 transferring from one to the other.

20 So, that was what I wanted to
21 update you on. I think a lot of the fixes that you
22 asked us for are ultimately budget fixes. Pay more, pay
23 more per unit, pay a Kentucky KenPAC access fee. It
24 kind of boils down to money.

25 And, so, the budget is an

1 important discussion. And the fact that it got cut from
2 what the Governor submitted, we'll have to come up with
3 some solution as to how we make that budget work and
4 it's not going to be easy, but we'll let you know on
5 that.

6 CHAIR PARTIN: Commissioner, where
7 did the tobacco funds go; into the General Fund?

8 COMMISSIONER KISSNER: You know, I
9 didn't do forensic accounting. It goes somewhere. It
10 could go to schools or hospitals. I don't know where it
11 goes. It just goes out of Medicaid to somewhere else.

12 CHAIR PARTIN: Okay. Thank you.

13 COMMISSIONER KISSNER: This was
14 the first time that any budget, by the way, that
15 Medicaid has ever gotten tobacco funds. So, that was
16 kind of cool. At least we started there.

17 DR. NEEL: You mentioned a Member
18 Handbook. We're having a huge problem especially since
19 January with co-pays for children. And I've talked to
20 Lisa, I've talked to the Department several times and
21 have been trying to straighten it out.

22 WellCare in particular has been
23 including co-pays on membership cards, and they tell us
24 that they issued the wrong cards and the wrong policies.
25 And this has just been a horrendous problem for those of

1 us in pediatrics in particular because unless they are
2 KCHIP, they don't have a co-pay. I believe I'm correct.
3 We've been through this over and over and over.

4 COMMISSIONER KISSNER: That's
5 correct.

6 DR. NEEL: The problem is getting
7 on the website, it no longer says if you're KCHIP or not
8 KCHIP. What it actually says is you have a co-pay or
9 you don't have a co-pay. And we have card after card
10 coming in every day that will show a \$3 co-pay, and,
11 then, when we get on the website, it says there is no
12 co-pay because they're not KCHIP.

13 WellCare I think is trying to
14 straighten it out, but so far we haven't, and I just
15 wanted you to be aware of it. It's a real problem for
16 us. I'm sure every pediatrician's office is dealing
17 with it. Have you all talked with WellCare at all?

18 COMMISSIONER KISSNER: No. That's
19 the first I've heard of that, that there was a card
20 issue problem. I don't know if somebody from WellCare
21 is in the audience.

22 MR. MIKE RIDENOUR: We were aware
23 of the problem and I think in communication with you as
24 well. And as far as we understand, it's been remedied.
25 Now, those cards should be out as we speak. So, it was

1 an error on our part and we've taken care of it.

2 DR. NEEL: I don't think it's
3 filtered down to the trenches yet as far as that's
4 concerned. I just wanted to make sure everybody was
5 aware of it. It's been a real headache.

6 MR. RIDENOUR: Absolutely we're on
7 top of it. Thank you.

8 MS. BRANHAM: I have one question
9 that relates to the Waiver. We have been talking with
10 Commissioner Anderson. That's part of the Home-and
11 Community-Based Waiver. Is that going to be additional
12 federal funding coming in to implement this new kind of
13 Waiver with Commissioner Anderson?

14 COMMISSIONER KISSNER: So, we have
15 submitted--we're coming up on the fifth year of our
16 Home- and Community-Based Waiver Program, and you have
17 to resubmit it completely. And the feds have issued
18 significant documentation on the new rules associated
19 with Home- and Community-Based Waivers and compliance
20 with that.

21 So, we submitted it in like the
22 first week in March. We submitted a modification to the
23 Home- and Community-Based Waiver and we're trying to
24 modify Year 5. So, that's been in and we're working
25 with the feds on the Q and A's back and forth on

1 clarification things.

2 After March 17th, after St.
3 Patty's Day, any change to a Waiver Program requires
4 that you comply with the new rules that are out. And
5 when you make a change, it triggers an event, and the
6 event is that within 120 days from the date you have
7 submitted your change, okay. So, this is going to hit
8 us in the summer.

9 I'm sure in June, we're going to
10 make some changes to the--let's say the budget gets
11 approved and we get some slots. We get new slots. So,
12 we need to submit to the feds and say, hey, we've got an
13 extra 100 slots in this program and we want
14 authorization to do that.

15 That will trigger in 120 days, you
16 have to send in a plan that is how I'm going to bring my
17 current program into compliance with these new rules.
18 They sent out 375 pages of stuff to read and comments.
19 It's just like the public comment period for the state.
20 Well, they have a public comment for the federal rules
21 and they have to respond to everything.

22 So, that's what most of the pages
23 are, and then the last forty pages are the actual reg
24 where they basically said we're going to keep it all
25 exactly as we said we would and we'll just comment.

1 But we have to create a plan that
2 says here's how we're going to bring this Waiver into
3 compliance in the next five years and they set the 120-
4 day thing. We didn't create that. Supports for
5 Community Living, Home- and Community-Based service, if
6 it's an HCB Waiver, you've got to bring it into
7 compliance and you have a short period of time.

8 MS. BRANHAM: So, that's what
9 we're in. That's what she's working towards with----

10 COMMISSIONER KISSNER: Well, we
11 got it in before the trigger date purposely because we
12 just wanted to modify Year 5 of the Waiver, but we would
13 have had to do it anyway because after it expires, you
14 have to do a whole other submission for another five-
15 year period. And each Waiver has its own Waiver year.

16 So, they come up for renewal. And
17 any change made triggers all of the changes and you have
18 to create a plan that says here's how I'm going to bring
19 it into compliance which means you've got to do the
20 analysis to say here's what's not in compliance today
21 and here's the changes over time.

22 And you have five years to
23 actually bring it into compliance. You don't have to be
24 compliant right away. You just have to create a plan
25 that says over time. So, if they say certain services

1 are no longer eligible or certain services have to be
2 provided, you have to create a plan that says here's how
3 I'm going to provide those services between now and five
4 years from now. Here's the transition plan to be
5 compliant. That's what they're looking for, and they
6 require it of every state and any change to a Waiver
7 Program. So, it's sort of a major deal, a lot of work
8 as soon as we trigger it.

9 CHAIR PARTIN: Any other questions
10 for the Commissioner?

11 MS. BRANHAM: I have one other
12 question that deals with the provider letter that was
13 issued in January that relates to therapies now being
14 covered and private duty nursing being covered and those
15 kinds of things.

16 At our last TAC, we briefly
17 touched on, and I've had trouble really mining the
18 information that I needed to give to our members, that
19 relates to the provider letter coming on saying - and
20 I'm just going to focus on home health, of course -
21 saying that now there's private duty services going to
22 be paid by Medicaid.

23 MS. HUGHES: It's in Section 9,
24 Sharon.

25 MS. BRANHAM: Thank you. So, it's

1 a new benefit and it limits it to 2,000 hours per year
2 and it came under an E reg.

3 I guess the one concern that I
4 have about this is I can't find any information relating
5 to this because it would appear that skilled nurse, LPN
6 and home health aide can all provide private duty
7 services and be reimbursed by Medicaid for these
8 services which is all new.

9 Now, we have thirteen PDN's in
10 Kentucky, and it's going to fall, the best I can tell,
11 fall under private duty nursing which would necessitate,
12 if anybody wanted to participate in this program, they
13 would have to apply for a certificate of need which
14 relates to additional costs applying for a certificate
15 of need. Well, it does to make an application for a
16 certificate of need, yes.

17 The application if you're an
18 existing agency is \$100. If not, it's \$1,000. You file
19 your application. If someone files as an affected
20 party, then, that involves attorneys. And I guess I
21 don't really see a benefit with this being able to be
22 provided if we don't have some kind of conduit other
23 than the certificate-of-need process to provide the
24 services for people who can qualify or who would qualify
25 for this service. I mean, we're trying to help you all

1 flip the books a little bit on keeping people out of
2 facilities and things such as that.

3 My experience recently has been,
4 just to maybe give you all some enlightenment, is that
5 some of the ALJ's are saying that emergency certificates
6 of need for one or more people cannot be granted. So,
7 this is just something that I wanted to bring to your
8 all's attention.

9 However, case history has proved
10 that emergency certificates of need to alleviate
11 emergency services for somebody that would like to have
12 this in a county where nowhere provides this have been
13 granted but the current sitting ALJ's say no.

14 So, I think Neville is the one who
15 communicated to me that there's just been one person
16 apply for a PDN since this kind of went out, since this
17 provider letter went out.

18 So, it's okay for an existing PDN
19 but I don't really see how this is going to be a
20 benefit, and I haven't been able to find any reg that
21 qualifies for different levels of payment.

22 I mean, we've got this, and I just
23 don't know how to translate it to action. And if I
24 translate it to action, then, how can I implement it
25 with these certain restrictions that relate to

1 certificate of need and relate to ALJ's believing that
2 you can't have emergency certificates of need which is
3 what you have to have before you can get certificates of
4 need.

5 So, I just wanted to bring it to
6 your attention and I don't know how to go forward and
7 would like some recommendations perhaps from you all
8 today as to how to do this.

9 COMMISSIONER KISSNER: I can't
10 comment on the certificate-of-need process. I need to
11 research that.

12 MS. BRANHAM: I know that you
13 can't and probably not until you do research it, but are
14 you all aware and where do I find the payment regs? Now
15 that I have finally got an answer that it does fall
16 under private duty - we have thirteen in the state - it
17 doesn't cover the state by any stretch of the
18 imagination - and if it's available, where can I go find
19 it? Who can give me my information? It's not Chapter
20 13.

21 MR. WISE: I don't know the reg
22 number, but we have a reg.

23 MS. BRANHAM: Just somebody
24 provide that to me so that I can communicate it to the
25 membership of the Kentucky Home Care Association that

1 relate to this, and then just giving some thought about
2 how it may not--I mean, it looks like it's going to be
3 part of the benefit plan, but really there's lots of
4 stumbling blocks related to it.

5 COMMISSIONER KISSNER: It is part
6 of the benefit plan. We have counties that don't have
7 dentists. We have counties that don't have lots of
8 services. We needed to add it to be in compliance with
9 ACA. So, that's how we got there.

10 It was covered under the Anthem
11 small group plan and became sort of part of the--when
12 you looked at the ten essential health benefits and the
13 different structures of the plan designs, this was one
14 of the few things that Medicaid actually didn't cover
15 that we needed to add to be in compliance. So, that's
16 how we got there.

17 It's a current benefit under the
18 commercial programs in the state, and it was the most
19 common small group plan sold in the State of Kentucky.
20 So, somebody is probably using it. It might not be
21 many. So, we just had to be in compliance with it.

22 We do have regs on it and we do
23 have payment structures. So, we just need to get you to
24 where those are but we have those.

25 CHAIR PARTIN: Let's move on to

1 the reports and recommendations from the TACs. First up
2 is Behavioral Health.

3 MS. HUGHES: The ones I've
4 received you all have copies of. They were not in the
5 binders. They are paper-clipped.

6 MS. VALERIE MUDD: Good afternoon.
7 I'm Valerie Mudd serving today as the spokesperson for
8 the Technical Advisory Committee on Behavioral Health on
9 which I serve as representative of consumers of mental
10 health services.

11 Our TAC had its most recent
12 meeting at the Capitol Annex on March 20th. We invited
13 all five of the MCO's and their behavioral health
14 representatives to attend and responded and sent
15 representatives to the meeting.

16 In addition the MCO's and the four
17 TAC members who were present, we had other members of
18 the behavioral health community in Kentucky, including
19 leadership from the Kentucky Mental Health Coalition and
20 the Children's Alliance.

21 A summary of the Behavioral Health
22 TAC report made to the MAC on November 13th was reviewed
23 and discussed. The focus then turned to the issues
24 which have been at the forefront of concern from the
25 behavioral health community, some of them since Medicaid

1 managed care began in November of 2011.

2 Those include access to
3 appropriate medications, hospitalization of sufficient
4 length-of-stays and stepdown services, utilizing Peer
5 Support Services, medical necessity criteria and
6 authorization of services, including consumers and
7 family members on MCO committees, access to integrated
8 care (behavioral and physical), resolution of payment
9 issues, greater transparency and medical necessity,
10 authorizations and denials, and need for standardization
11 of forms and processes across MCO's.

12 There was open dialogue about all
13 of these issues with consumers, family members and
14 providers asking for clarification of policies, noting
15 the difficulty with medical necessity criteria that is
16 proprietary and not readily available.

17 Providers noted the difficulty of
18 not having common ground on medical review criteria.
19 This led to a discussion about the administrative burden
20 experienced by those providers (CHMC's, private child-
21 care facilities) who have contracts with all five MCO's,
22 each with its own forms, procedures, criteria, etcetera.
23 The lack of consistency of forms and procedures creates
24 a huge administrative and resource burden for providers.

25 A recommendation we have is that

1 representatives of the Behavioral Health TAC or their
2 designees be invited to attend a meeting of the MCO
3 Medical Directors to discuss this issue of inconsistency
4 of forms and procedures across the MCO's in order to
5 seek some resolution which would reduce administrative
6 costs and burden for providers and facilitate service
7 provision.

8 The ongoing problems with access
9 to appropriate medications were discussed, particularly
10 in regard to Abilify and other injectables. Actually, I
11 asked the question about this, and they told me if I saw
12 any commercials on TV, that those would not be
13 authorized.

14 The MCO's clarified that in most
15 cases, injectables would not be authorized without
16 documentation of a trial of at least four to six weeks
17 on the oral medication. Lack of accurate patient
18 records is a problem in this regard. Prescriber
19 education is an important part of dealing with the prior
20 authorization process.

21 The previous recommendation we
22 had: The requested data for PA's and their outcomes for
23 psychotropic medications has not been yet completed by
24 DMS but will be forwarded to the Behavioral Health TAC
25 within the next month to six weeks. Once that data has

1 been received and reviewed by the Behavioral Health TAC,
2 further recommendation to improve medication access may
3 be forthcoming.

4 There continues to be concerns
5 around the high denial rates for outpatient therapy
6 services, particularly by one of the MCO's, and the
7 short length of stay in the hospital for behavioral
8 health patients, particularly children. Some of the
9 MCO's suggested direct contact with their behavioral
10 health director to discuss these situations. That
11 contact information will be disseminated.

12 The issue of reimbursing for Peer
13 Support Services was discussed. We were pleased to hear
14 that nearly all of the MCO's are including this service
15 at this point in time and that a majority of the CMHC's
16 have signed off on their contracts. That's great.

17 At our meeting six months ago with
18 the MCO's, there was a request for improved
19 communication and more opportunities for consumers and
20 family members to participate on their committees. The
21 MCO's indicated their interest in both of these areas
22 but also noted the difficulty that they were
23 encountering in identifying members who were interested
24 in serving and actually attending meetings. Utilizing
25 the network of the Kentucky Mental Health Coalition,

1 information and recruitment materials will be circulated
2 from the MCO's and back to them.

3 Concerns were noted with the low
4 Medicaid rates posted by Kentucky DMS, with providers
5 feeling that they were not sufficient to cover their
6 costs. Comments regarding these rates have been made by
7 various provider groups in response to the Medicaid
8 regulations. Responses to those comments have not been
9 issued.

10 The major concern expressed was
11 that if front-end services were not sufficiently
12 available because of low rates and, therefore, reduced
13 number of providers, members - especially children and
14 those with significant behavioral health issues - would
15 end up in much more costly treatment settings or being
16 placed out of state.

17 A recommendation we have is that
18 Kentucky DMS review carefully the comments made by
19 providers in response to the published rates, and in
20 particular, examine the rates for services such as
21 intensive case management and outpatient therapies which
22 could prevent higher-cost, more restrictive treatment
23 approaches from being needed.

24 The TAC member representing the
25 Brain Injury Alliance of Kentucky was unable to attend

1 the meeting but noted these concerns. Individuals with
2 brain injuries are being denied the medication
3 prescribed by their doctors.

4 ABI Waiver clients are being
5 dropped into managed care automatically by the system.
6 They should be placed in Comprehensive Choices. Until
7 this is corrected, Medicaid will not pay for Waiver and
8 other medically necessary services.

9 State guardianship clients are
10 being kicked out of the Medicaid system because their
11 resources are too high and either Guardianship or
12 Fiduciary are not catching this until it's too late.
13 There needs to be a system in place to flag responsible
14 parties before this happens.

15 The number of people on the
16 waiting list for Medicaid ABI Acute Rehab Waiver is 193
17 and the Medicaid ABI Long-Term Care Waiver is 124.

18 Finally, the Behavioral Health TAC
19 wishes to state again the recommendations made a year
20 ago, that a Behavioral Health Ombudsman be established
21 to provide easily-accessed personal responses to
22 consumers who are experiencing difficulty with the
23 managed care system. This would allow consumers to
24 share their personal health information as they discuss
25 directly with the Ombudsman the issues that need to be

1 resolved with the MCO's in order for them to access the
2 care they need.

3 That you for providing this forum
4 to bring forward behavioral health concerns on behalf of
5 the Medicaid members.

6 CHAIR PARTIN: Thank you. Rather
7 than vote on each one of these individually to accept
8 the reports, I would just like to do it at the end, just
9 do a blanket approval, if that's okay with the
10 committee, and then we'll be asking for a response to
11 all the recommendations in each report. Dental.

12 DR. RILEY: Dental does not have a
13 report at this time. We haven't had a meeting since
14 September.

15 CHAIR PARTIN: Thank you. Nursing
16 Home Care.

17 MR. FOLEY: No report.

18 CHAIR PARTIN: Home Health Care.

19 MS. BRANHAM: I touched on a
20 little bit of what we talked about in our last TAC
21 meeting which occurred last week for the private duty
22 service expansion and getting that information.

23 Second is we've talked a little
24 bit about it as well in the Old Business and that is the
25 increased cost from repetitive and quickly prior

1 authorizations for particularly Waiver patients and no
2 consensus from around the state as to how that's
3 applied.

4 Karen Martin is working with the
5 MCO's in relation to trying to get some sort of common
6 thread, again, and diagnoses that relate to why one kid
7 can get approved for a period of time. I mean, we're
8 talking a lot today here about cutting expenses and no
9 money for doing other things. Yet, it seems like we're
10 always in a crisis standard of care or trying to provide
11 care, standard of care, but it's always increasing costs
12 on the administrative end, both for the MCO's and for
13 the providers trying to do that. I think that's one
14 common thread that we've heard throughout our meetings
15 here.

16 I have been sitting here since
17 11:00 and it seems like we just can't continue to be
18 placed in situations by the managed care organizations
19 that are very restrictive and at times even I guess - I
20 don't really know the correct word to say - but it's
21 restrictive in the manner in which you're trying to
22 provide a standard-of-care accountability of what you're
23 held to.

24 We're always fighting over prior
25 authorizations, we're fighting over payments, and it's

1 issues that continue to crop up that are resolved, yet,
2 they come back and we're over two years into this. And
3 I guess I don't really understand how we can provide a
4 good quality of care when these are the issues that
5 continue to be the driving force in providers doing more
6 with less.

7 And I don't know how really to
8 address this, but I think this is the body to address
9 this; but I believe that the MCO's behave in an
10 irrational and self-serving manner which don't allow
11 providers in the state to do what we need to do to care
12 for the population in which we're charged with caring.

13 And I urge this Council, along
14 with those in the managed care, along with the Cabinet
15 and the Commissioner and the Secretary, let's try to
16 make this work with what we have and work in a fair and
17 equitable manner better for the patients and for the
18 providers because, as I sit here, it's repetitive, it's
19 repetitive, it's repetitive. I see things that have
20 been sitting here on the table for a year and we've not
21 resolved.

22 So, I can sit here and I can go
23 over these TAC notes and what we've talked about doing,
24 but really it comes back to managed care wanting to work
25 with providers in the State of Kentucky to care for the

1 patients in which they're charged to care for. That's
2 it.

3 CHAIR PARTIN: Thank you.
4 Hospital Care.

5 MR. HERDE: Good afternoon. My
6 name is Carl Herde and I do serve as the Chair of the
7 Hospital TAC. And with me I have Nancy Galvagni from
8 KHA. We appreciate this opportunity to give you an
9 update from the last meeting and what has happened since
10 then, specifically related to the DRG regulation.

11 As I mentioned at the last meeting
12 here and as noted on the agenda under the Old Business,
13 the TAC had made several recommendations to the Cabinet
14 before they actually originally filed the amended DRG
15 regulation. These recommendations were rejected by the
16 Cabinet without any explanation back to the TAC as to
17 why.

18 To briefly recap the issues, the
19 TAC had requested a transition period to phase in
20 changes to each hospital's Medicaid rate in order to
21 minimize the amount of losses that individual hospitals
22 will experience under the new regulation. These losses
23 amount to millions of dollars for some providers.

24 Providing a transition is
25 consistent with other states implementing similar DRG

1 that meeting, the TAC was informed by the Cabinet staff
2 that we could not discuss any of the comments because
3 the Cabinet was in the process of preparing their formal
4 responses.

5 At the last meeting, I also
6 mentioned that the hospitals and KHA would still be
7 reviewing the proposed regulation and that KHA would be
8 gathering comments through the hospitals and submitting
9 additional comments to the Cabinet.

10 The TAC has not met collectively
11 to discuss the issues that were raised through the
12 comment period, not the least of which was we were
13 offered dates subsequent to March 15th after the formal
14 responses were done which were actually issued on March
15 14th. So, it didn't seem to make any sense to meet with
16 the Cabinet when the formal response was already in
17 place.

18 And I understand that there had
19 not been any changes to the regulations or to the two
20 issues we raised here last time or to the comments that
21 have been submitted subsequently.

22 And with me is Nancy Galvagni.
23 KHA has gone through and collected the comments through
24 the hospitals and also have the submission. So, she's
25 going to review through those comments.

1 MS. GALVAGNI: Thank you. KHA did
2 raise several additional concerns in writing through the
3 public comment period, and these were really issues that
4 were never discussed with the TAC at all in any of our
5 meetings. So, they were complete surprises to us.

6 And I'm just going to hit a few of
7 the highlights. First, there was a significant concern
8 because the way the regulation is written, it talks
9 about how rates are going to be updated. So, in four
10 years from the current system, they will be rebased or
11 updated.

12 And under this regulation, it
13 indicates that the Cabinet won't use any claims data
14 from Medicaid recipients who are covered by MCO's which
15 has the effect of only using about 10% of the claims
16 from 10% of the recipients because most of the
17 recipients are in MCO's. Only about 10% of the
18 recipients are not, and those primarily tend to be
19 institutionalized adults.

20 And, so, we have a concern with
21 that. And just to give you some perspective, the
22 Cabinet and its consultants used about 96,000 claims to
23 set the rates under this new DRG system, but only about
24 40% of those or 39,000 were for adult services, the rest
25 being pediatric. Pretty much almost 50% were OB and

1 newborn claims or pediatric claims.

2 So, therefore, by excluding the
3 MCO data, you're going to drop the number of future
4 claims from like 96,000 to maybe less than 5,000 claims
5 to set future rates.

6 In addition, the rate system makes
7 specific policy adjustments for payments made for OB and
8 newborn services; but since you're not going to have any
9 of those claims in the future rate-setting, it kind of
10 makes no sense to have these adjustments because who is
11 going to pay for that?

12 So, we think that that's a
13 significant problem. There's just too small of a number
14 of claims when we go to look at future rates to have
15 anything that's valid. And the rate system affects not
16 only the fee-for-service program but all the MCO
17 contracts because most of the MCO contracts are tying
18 their payments to the fee-for-service system. It's also
19 not in keeping with how DRG rates are set in other
20 states such as Ohio that also have MCO's.

21 Another major concern with the
22 system that was never talked about with the Hospital TAC
23 imposes a system to reduce payments in future years if
24 the severity of patients being treated in a hospital
25 increases by more than an arbitrary percentage that's

1 set out in the regulation.

2 And we have concerns with that
3 because there's many things that are happening in
4 healthcare that are moving more care to the outpatient
5 setting. There's new federal rules called the Two-
6 Midnight Rules that talk about when a patient is in
7 observation versus when they can be admitted. The MCO's
8 have new criteria.

9 So, all of these forces are coming
10 to play, and we feel that it's very likely that the
11 severity of the patients that are actually hospitalized
12 are going to be much higher than this arbitrary
13 percentage that the Cabinet has put in the regulation
14 without any basis to support it.

15 Finally but importantly, the
16 Cabinet has made changes in the ability of hospitals to
17 appeal their individual rates. And, once again, this
18 was never talked or discussed in any of our TAC
19 meetings.

20 Our outside legal counsel believes
21 that the changes are unconstitutional because it
22 virtually eliminates the ability of any individual
23 hospital to appeal their rate for any reason.

24 As Carl said, the Cabinet made no
25 revision to the regulation to address any of these

1 specific concerns. And pretty much the response that
2 was given back to most all the comments is that the
3 regulation has to be implemented immediately in order to
4 comply with ICD-10 which becomes effective in October.
5 Well, it was to become effective in October of this
6 year. There's been a change on that, but that's simply
7 not the case.

8 The Department does need to update
9 to an ICD-10 complying grouper. A grouper is only one
10 part of a DRG system. All that does, it's a method to
11 group claims based on how they're coding into categories
12 for payment. It doesn't entail changing the rate
13 structure. You don't have to make a wholesale change to
14 the payment system just to update that one component.

15 And, in fact, the Cabinet has
16 known about the need to update their grouper for quite
17 some time and taken no action. As Carl mentioned, at
18 the last meeting back in July of 2012 which was the last
19 time that the DRG rates were completely updated, the TAC
20 had already recommended that the Cabinet adopt a
21 different grouper that would be compliant with ICD-10.
22 And at that time, the Cabinet deliberately decided to
23 delay and take no action.

24 So, to say now that, well, we have
25 to rush this regulation through and we can't make any

1 changes because we have to comply with ICD-10, that's
2 really not the case.

3 In addition, there's been an
4 additional change that's happened with respect to ICD-
5 10. We just got word this morning from our Washington
6 lobbyist that Congress has passed a bill to fix the
7 sustainable growth rate for physicians. It's included a
8 lot of other things in that, and included in that is
9 another one-year delay in the ICD-10, and that's already
10 passed the House of Representatives and is supposed to
11 pass the Senate today.

12 So, once again, there's just no
13 need to rush this regulation through, to not listen to
14 any of the comments or to work with the TAC on making
15 these important changes.

16 KHA did formally through its
17 comments request that the Cabinet defer this rule and
18 work through the issues with the TAC before moving
19 forward to make a wholesale change to the payment
20 system.

21 And we still believe that this is
22 an appropriate course of action, particularly with the
23 ICD-10 being delayed another year. There's just plenty
24 of time to work through these issues without imposing
25 these major changes to hospitals that are going to reek

1 havoc for many of them, given the major redistribution
2 of Medicaid payments under this new system.

3 MR. CARLE: So, just to clarify,
4 the Cabinet has never given you a formal response based
5 on the questions and the information that you provided
6 to them that you've just reviewed.

7 MS. GALVAGNI: The Cabinet made a
8 written response to the comments, and the written
9 response was we have to comply with ICD-10. So, we
10 can't transition. We can't make any changes. We have
11 to comply with ICD-10. We don't have time to do
12 anything. So, that was the response.

13 MR. CARLE: But based on what is
14 happening today in Washington, it's a moot point at this
15 point in time.

16 MS. GALVAGNI: Correct.

17 CHAIR PARTIN: Thank you very
18 much.

19 Nursing. I will give that report.
20 Many of these issues relate to the MCO's that I'm going
21 to be bringing forward today. And, so, I would like to
22 get a response from the respective MCO's if I could.

23 MS. HUGHES: They will need to
24 come to the table.

25 CHAIR PARTIN: Yes, ma'am, they

1 do, but I will wait until I bring up the points and then
2 the respective companies can come forward.

3 The first point is that the MCO's
4 are not including nurse practitioners on the Exchange so
5 that patients may choose an APRN as a primary care
6 provider.

7 As of March 11th, Anthem had not
8 listed APRN's but said that they would have all APRN's
9 listed within 24 hours who were participating. And I see
10 we have a list here.

11 And obviously I haven't had a
12 chance to go through this list to see; but picking up on
13 what the Commissioner said, there is no easy way for
14 those who are not participating in a plan to look up and
15 see who the participating providers are.

16 I tried to go through the website
17 and tried to see if I was listed and I could not find
18 any way to find providers who are listed with any of the
19 MCO's. So, if there is a way, then, I would appreciate
20 having that information and sharing that with other
21 providers.

22 The Humana Health Source does not
23 have nurse practitioners included in the Exchange. A
24 Health Source representative said the company planned to
25 list nurse practitioners but didn't know when it would

1 happen. I do see that there are some nurse
2 practitioners listed just briefly looking at this under
3 the Humana. I didn't see my name. So, I'll be looking
4 for that to see if that is there.

5 And, then, again, my point, only
6 those enrolled are able to view the providers to choose
7 a provider. There needs to be a way that everybody can
8 look at that list and see who is participating and it
9 needs to be fairly easy and accessible.

10 Number 2: WellCare, Coventry,
11 Humana Care Source and MHNNet have informed APRN's of the
12 policy that the physician who has signed the APRN's
13 prescribing agreement must also be credentialed with
14 their company.

15 WellCare has recently sent out
16 notices to advise APRN's that if the physician is not
17 enrolled, then, the APRN will be "termed" from the
18 WellCare network. That means that if a physician
19 chooses not to participate with an MCO, that for now -
20 the only formal information I have is from WellCare -
21 that WellCare is going to kick the nurse practitioners
22 off of their panel.

23 And I don't think that's
24 acceptable and I don't think that's what the Department
25 for Medicaid Services intends to be in place. I think

1 that they want as many healthcare providers as possible
2 providing care and access for patients. And, so, to
3 kick people off because a physician who is not related
4 to that APRN's practice is not participating I find not
5 acceptable.

6 The Kentucky APRN's currently have
7 a prescribing agreement with physicians. As of July,
8 APRN's who have four years' experience or have been
9 licensed for four years will no longer have to have a
10 prescribing agreement. And this prescribing agreement,
11 as I say, is a prescribing agreement. It has nothing to
12 do with practice. So, this requirement by the companies
13 seems to be arbitrary and not realistic as to what's
14 happening out in the real world.

15 Some APRN's have independent
16 practices. They cannot induce a physician who has
17 signed a prescribing agreement to participate in a
18 particular plan. And, so, again, this will decrease
19 access to care, particularly in those areas where a
20 nurse practitioner or an APRN is the only healthcare
21 provider in that community.

22 So, on this particular issue, I
23 would like to have the MCO's speak, but let me go
24 through because there are some other issues here for the
25 MCO's as well.

1 People who are enrolling in the
2 Medicaid MCO plans are frequently assigned providers who
3 they have never seen or whom they do not wish to see,
4 even if the person requests a specific provider.

5 I've had this experience myself
6 where patients have told me they tried to have me listed
7 as their provider and they were told they had to choose
8 a different provider, even though I am credentialed with
9 all of the MCO's.

10 Each of the MCO's uses different
11 procedures and forms, and this was touched on in the
12 Behavioral TAC report. It's a nightmare. It is truly a
13 nightmare to try and comply with all of the requirements
14 for preauthorization procedures, referrals or medication
15 with each company having different forms and different
16 processes and some of the companies asking us to go
17 online, some of them telling us they want paper, some
18 wanting us to fax it, some wanting us to call, and then
19 when you call, the requirements are all different. You
20 never know what you're supposed to do for which MCO.
21 And even if you were told one day, it's hard to remember
22 three weeks from now what that particular requirement
23 was.

24 So, I would like to have that
25 issue addressed, and that one may not be able to be

1 addressed today.

2 MCO's have recently begun
3 requesting information from practices regarding quality
4 measures. In some instances, these requests are for all
5 records for 2013. The request is to either fax or mail
6 the records.

7 For patients who have had monthly
8 visits and whose charts are electronic, this amounts to
9 a significant workload for the staff and a significant
10 cost for mailing and printing.

11 For those of you who are not
12 familiar with electronic health records, it's not just
13 one page for an encounter. It's five. And if they have
14 a lot of chronic illnesses, it might be ten pages. And
15 if you have one visit every month and you have ten pages
16 for each visit that you have to print out and either
17 fax, which is impossible because that's too many pages
18 to fax, or mail which is costly when you get a request
19 for several patients.

20 Yesterday we had to I think do
21 five of those at our office, a full year printout of all
22 the encounters, and I think that's a little bit
23 unreasonable.

24 If the MCO's want information on a
25 particular quality indicator, then, we should be able to

1 send information on that particular indicator and not
2 have to send copies for the whole year of the whole
3 chart.

4 And, then, finally, providers are
5 required to perform school, sports, pre-surgical exams,
6 physicals for foster children every time they are placed
7 in a new home, but reimbursement is only permitted for
8 one annual exam per year.

9 If a person has an exam at the
10 beginning of the year, that evaluation is not valid
11 eleven months later, and, so, the exam has to be
12 repeated but there is no reimbursement for that physical
13 and no way to code it because you can only code one
14 physical.

15 So, the recommendations would be
16 that all MCO's be required to list participating APRN's;
17 providers and others who are not enrolled in a
18 particular plan have access to view the list of
19 participating providers; that any Medicaid MCO and their
20 affiliated organizations remove requirements that a
21 physician who has signed a prescribing agreement with an
22 APRN must also participate in that same plan; that
23 people be permitted to choose their primary care
24 provider and that provider assignments be appropriate -
25 and this has been brought up numerous times in this

1 committee that patients are assigned to providers who
2 don't provide primary care or who don't provide primary
3 care appropriate for that age group; that uniformity be
4 developed for preauthorization procedures and forms;
5 that requests for quality measures be narrowed down so
6 that the whole year of full encounters and lab work do
7 not need to be printed and faxed or mailed, and that
8 methods to enable the sending of records from an EHR via
9 computer should be implemented; and that a method for
10 coding the various physical exams and providing
11 appropriate reimbursement when more than one exam is
12 required in a year should be developed and implemented.

13 I would like the representatives
14 from WellCare, Coventry, Humana - and I don't think
15 anybody from MHNet is here - to come forward and address
16 the issue of the requirement that a physician that has
17 signed a prescribing agreement with an APRN also
18 participate in the plan.

19 MR. LAWRENCE FORD: Dr. Partin,
20 thank you. My name is Lawrence Ford. I'm Director of
21 Government Relations with Anthem Blue Cross Blue Shield.
22 We are happy to address each point that you raised. I
23 was not provided advanced notice that you had these
24 specific points, so, I'm not prepared to address them
25 right now.

1 As far as the APRN, you say that
2 they're not being included in the Exchange plans. Are
3 you referring to MCO's or are you referring to QHP's on
4 the commercial side?

5 CHAIR PARTIN: Well, all I can
6 address here is the MCO's, but, yeah, they're not
7 included in the other.

8 MR. FORD: Okay. As far as the
9 prescriptive authority and the collaborative agreements
10 or the agreements with the providers, I believe that is
11 new legislation that was passed this year.

12 CHAIR PARTIN: You mean to do away
13 with it?

14 MR. FORD: Yes.

15 CHAIR PARTIN: Yes, but the
16 agreement was only a prescribing agreement. But,
17 furthermore, it's not reasonable to require a physician
18 to participate in a plan that he or she doesn't want to
19 participate in.

20 MR. FORD: We'll be happy to
21 address that.

22 The persons not being assigned to
23 providers that they know, that they've seen, that
24 they've chosen, we're happy to address these and we'll
25 address them in writing within the next five business

1 days, if that's okay.

2 CHAIR PARTIN: That would be
3 excellent.

4 MR. FORD: And, then, lastly,
5 foster children and the frequent examinations, there's
6 been discussion and actually even legislation introduced
7 this year to address the managed care needs of foster
8 children because it is a unique population, that they
9 are assigned to different homes across the state. A
10 Medicaid managed care plan may or may not be following
11 those children.

12 So, I think that's a unique
13 population and something that we look forward to having
14 discussions with the Cabinet on how to best address that
15 specific population.

16 CHAIR PARTIN: And it's not just
17 the foster children. That was just one example. There
18 are sports physicals, there's pre-surgery physicals,
19 there's annual exams that we're required to do.

20 MR. FORD: Right. And I tried to
21 capture all of these, and I'm sure that we can probably
22 get them from the----

23 CHAIR PARTIN: Sharley has a
24 written----

25 MR. FORD: Sharley, I know you'll

1 find me, but we're happy to reply and we'll do so as
2 quickly as possible.

3 CHAIR PARTIN: Okay. Thank you.

4 MR. RIDENOUR: Mike Ridenour from
5 WellCare. First of all, the issue that you mentioned
6 with--could we get a copy of that letter that you
7 received from WellCare because it doesn't comport with
8 what we know at this point. So, we need to investigate
9 that. So, if you can get us a copy of that and we'll do
10 some investigation on that one. Is this a letter? Oh,
11 this is an email.

12 CHAIR PARTIN: It's an email.

13 MR. RIDENOUR: We'll take a look
14 at this because it doesn't--oh, she's saying WellCare
15 has advised us.

16 CHAIR PARTIN: Well, no. In the
17 bottom is the message from WellCare saying that if----

18 MR. RIDENOUR: Chc.net.

19 CHAIR PARTIN: This is the
20 coordinator for WellCare at the bottom, and it says that
21 WellCare has advised us that if the nurse practitioner
22 does not have a collaborative agreement with a
23 participating WellCare provider, meaning physician, they
24 will be termed from the WellCare network.

25 MR. RIDENOUR: This person right

1 here?

2 CHAIR PARTIN: Yes.

3 MR. RIDENOUR: Oh, okay. It's
4 Center Care. I don't think that's right, but we'll
5 investigate and we'll get back to you because it doesn't
6 comport with what I and my Provider Relations Director--
7 I mean, this was news to us. We thought what? That
8 doesn't make sense. So, we can get to the bottom of
9 that. I think you were ill-advised.

10 DR. NEEL: It doesn't make any
11 sense.

12 MR. RIDENOUR: It's very clear in
13 our provider manual that they can dependent or
14 independent, but we'll get to the bottom of that.

15 CHAIR PARTIN: But WellCare is not
16 the only company. I don't have it with me but the other
17 companies that I mentioned also have policies but they
18 haven't received any notices saying that they're going
19 to be termed.

20 MR. RIDENOUR: Like I said, let us
21 investigate this and we'll touch base with Center Care
22 as well and just get clarification back to you.

23 And on the other issues, you
24 raised a number of questions that we just heard for the
25 first time. With all due respect, I would encourage the

1 MAC to submit those to the Department and have the
2 Department request----

3 CHAIR PARTIN: You will have
4 those. I didn't expect an answer on all those issues,
5 just that one particular issue because that has a lot of
6 people upset.

7 MR. RIDENOUR: I think there's
8 some miscommunications going on here but we'll get to
9 the bottom of it.

10 CHAIR PARTIN: From MH.net.
11 That's a psychiatric subsidiary and I'm not sure which
12 MCO they're associated with.

13 MR. RIDENOUR: Not us.

14 CHAIR PARTIN: But they have a
15 policy and I've also seen a Coventry policy.

16 MR. RIDENOUR: Well, that's a
17 perfect segway. Thank you.

18 DR. NEEL: This is a little
19 similar to what happened with physicians a year or so
20 ago when we were told that if our hospital would not be
21 part of the WellCare network, for example, or
22 CoventryCare, whichever it was at that point, then, the
23 physicians would then no longer be able to be part of
24 it. So, it's kind of similar to that. That turned out
25 not to be true, but that put fear amongst the troops

1 there for a bit.

2 MR. RIDENOUR: When you have an
3 entity, though, acting on behalf and these
4 communications are going out, we need to get to the
5 bottom of that and straighten it out.

6 CHAIR PARTIN: Okay.

7 MR. RUSSELL HARPER: Russell
8 Harper, Coventry - Aetna. And like Lawrence and Mike
9 just said, when we get those, we'll definitely respond
10 to the issues that you brought up.

11 I guess the clarifying question I
12 had on the first one was when you were talking about
13 listing the APRN's, is that on the Exchange, on the
14 Kynect site?

15 CHAIR PARTIN: Yes.

16 MR. HARPER: That may be something
17 we need to work with them on. It may not be loading
18 correctly because we know that there were some provider
19 issues as far as listings when they first set those up.
20 So, it may be something that wasn't checked in the
21 correct box or something.

22 CHAIR PARTIN: It was Anthem and
23 Humana specifically. With WellCare and Coventry, I've
24 had my name listed as far as patients being able to
25 choose, but it was the other issue specifically with

1 Coventry.

2 MR. HARPER: And theirs may be a
3 situation where they're both on the commercial side and
4 the Medicaid side, too. So, it may be something like
5 that, but that's their deal.

6 CHAIR PARTIN: Right, but with
7 Coventry requiring physicians to be credentialed if the
8 APRN is credentialed, do you have any information about
9 that?

10 MR. HARPER: I do not. I will
11 have to take that back to our provider team and our
12 operational folks and understand what that is.

13 CHAIR PARTIN: Okay, and then send
14 me a response.

15 MR. HARPER: Yes, ma'am.

16 CHAIR PARTIN: Thank you.

17 DR. NEEL: I'd like to comment on
18 one of your things there, and it has to do with the
19 HEDIS measures. I don't think any of us have a problem
20 with the HEDIS measures which are basically quality
21 issues that are things that really the Department did
22 not do before or did not do much of before managed care,
23 and now I understand that those are important to quality
24 of care.

25 The problem that we're having and

1 part of what Beth is saying is that we're being asked to
2 provide data which takes time to prepare. For example,
3 I got this week a notice that we needed 37 charts within
4 the next ten days of all the things that had happened to
5 those patients during the last year or two years.

6 The problem is that the data being
7 provided by the MCO's is poor data. For example, I get
8 a list of 500 patients of mine that's listed
9 alphabetically by first name. Where did that come from?
10 I was trying to go through those. We get lists of
11 children who need physicals who have not had one within
12 the last year, and the data is really hard to mine
13 through because much of that is false data.

14 So, I think the thing the
15 Department needs to understand and work with the MCO's
16 and to those of us out there is trying to perfect the
17 data or at least make better data for us to work with
18 because it takes a lot of time. She's talking about
19 those that have electronic medical records. For those
20 of us who don't, it just takes hours to go through these
21 charts and come up with all the information that they're
22 requiring.

23 And we all think it's important
24 because it's important to quality care. And, so, I
25 don't deny that, but it's the way it's being done right

1 now. If we don't improve the data, we're not going to
2 be able to respond well, and I just wanted to make that
3 point.

4 CHAIR PARTIN: Absolutely.

5 Absolutely.

6 DR. NEEL: I don't know if other
7 providers are having the same problem or not.
8 Optometrists, are you all getting requests for HEDIS
9 data as far as quality of care on your patients?

10 DR. WATKINS: I haven't as of yet
11 and I've not heard of any others to this point.

12 CHAIR PARTIN: And those lists,
13 too, we've received lists of patients and saying that
14 the patient requires a physical or they require an eye
15 exam or they require a hemoglobin A1C and they're not
16 even patients that have come to your practice ever, but
17 we're told that we're responsible for providing that
18 care and that that will be held against us if we don't,
19 but there's no phone number to contact the patient with.
20 And like you said, sometimes it is alphabetical by first
21 name. So, it is really kind of crazy. I've got those
22 lists in a pile. That's about as far as it's gotten.

23 DR. NEEL: Here is a list of 50
24 patients that our data says are your patients that were
25 seen in the emergency room in the last six months, and

1 we'd like for you to see if that emergency room problem
2 has been resolved. What has that got to do with it when
3 they were six months old? And, then, we're also
4 concerned that those patients went to the emergency room
5 and really did not have an emergency problem.

6 Now, there's no information given
7 to us except the date of birth and the patient's name
8 and that they're assigned to us. So, how do we find out
9 that they actually went to the emergency room? There's
10 no dates or anything. So, then, we have to get on our
11 computer, go through and find out when did they go to
12 the emergency room, what was the problem.

13 So, all of these are good things
14 but the data is just so poor that we're being given.
15 So, it's all being pushed on us to do and we just don't
16 have the time to do it.

17 CHAIR PARTIN: Thank you. We do
18 have a short report here from the Children's Health TAC.
19 I think everybody has a copy of it. It's just a short
20 little report. I'll just read this quickly.

21 It says: The Children's Health
22 Technical Advisory Committee would like to recommend to
23 the Advisory Council for Medical Assistance that
24 certified asthma educators are added as independent,
25 licensed Medicaid providers and be reimbursed at no less

1 than the standard Medicare rate. This recommendation
2 was made and approved at the March 14, 2014 meeting of
3 the Children's TAC from the majority members in
4 attendance, and it's signed by Mary Burch. So, if we
5 could have that entered into the record, please.

6 Next is Optometry, and I believe
7 you said you didn't have a report.

8 DR. WATKINS: I do not have a TAC
9 report, no.

10 CHAIR PARTIN: Therapy Services.

11 MS. BETH ENNIS: Good afternoon.

12 I'm Beth Ennis. I'm the Chair of the Therapy TAC. I'm
13 going to be one of the few good-news people today which
14 is kind of fun.

15 We did submit a list of questions
16 that was approved by the MAC to be submitted to the
17 Cabinet for a response and we did get that response. I
18 believe it was forwarded to me on Monday morning which
19 was the same time as our last meeting. So, we were able
20 to go through that.

21 And I want to thank the Cabinet
22 also for including questions that came from agencies
23 that are supporting of therapists. KPTA had submitted
24 some questions to the Cabinet separately and they
25 responded to those in that letter as well. So, we were

1 able to get all of that information back to them.

2 It did clear up a lot of different
3 things, but we are still having provider enrollment
4 issues with going to MCO's and MCO's still directing
5 people back to the Cabinet for enrollment. So, we're
6 working through that with them.

7 We also had a quick additional
8 meeting this morning that was posted on Monday during
9 our last meeting because we needed to get some
10 additional information.

11 And the only concern that has come
12 up based on that is the fee differential for therapists
13 versus assistants and how that is going to be applied
14 evenly across providers because hospital-based providers
15 are able to bill under the NPI of the hospital, and, so,
16 there isn't necessarily a provider NPI attached to that.
17 And how will they know that it's a therapist versus an
18 assistant versus a private practice or outpatient clinic
19 that bills both the facility NPI and the provider NPI?
20 And if it's an assistant that's providing that care,
21 it's a significant cut.

22 And we know rates are a problem
23 and budget is a problem and we know that that's going to
24 be a hard road to hold but we would like the Cabinet to
25 look at that and just see how that's going to be applied

1 appropriately across.

2 We are still hearing some vague
3 issues with denials, and I think that came up with the
4 Home Health TAC as well. So, what we would like to try
5 and do, in listening to Sharon, I think we need to get
6 together.

7 We were planning on doing some
8 specific data surveying to get specific information, not
9 necessarily on which patients but where the denials are
10 coming, how they're following up on them, are they
11 getting approved down the line so that we can give the
12 MAC some more specific information with some
13 recommendations to get back to the MCO's with.

14 We also appreciate continuing to
15 get a binder since we do not have a person on the MAC.
16 So, I have a stack at my house, too, but it's good
17 information for us to have as we go because that may
18 give us some information we don't have to gather.

19 We also appreciate the Cabinet
20 looking at the speech billing code issue and resolving
21 that fairly quickly. So, those new codes are in place.
22 And that's all I have.

23 CHAIR PARTIN: So, you just have
24 the one recommendation right now?

25 MS. ENNIS: Just the one

1 recommendation, if they would look at that differential
2 and how it's going to be applied across practices.

3 CHAIR PARTIN: And will you submit
4 that in writing?

5 MS. ENNIS: I will because we
6 didn't have a chance to get minutes in since we met this
7 week.

8 CHAIR PARTIN: But we can still
9 approve it today.

10 MS. ENNIS: Great. Thank you very
11 much.

12 CHAIR PARTIN: Physician
13 Services.

14 DR. NEEL: The Physicians TAC
15 actually met before our last meeting and I brought the
16 recommendations to the MAC meeting. And the
17 Commissioner asked that we put that into writing and
18 present it to the MAC so that it could be made as a
19 recommendation and it's fairly succinct in what we're
20 recommending.

21 We recommend that the per member
22 per month payment to primary care providers be
23 reinstated to ensure that a medical home is provided
24 for Medicaid recipients improving access to quality
25 medical care. Providers would be required to meet

1 certain HEDIS measures to receive the payments. This
2 will be particularly important if the ACA enhanced
3 payments are not extended past 2014.

4 I understand that the budget
5 presented by the President actually includes a
6 recommendation of a one year. So, we may be able to
7 kick that can down the road a little further. However,
8 it is impossible for primary care providers that are
9 paid under fee-for-service and that includes physicians
10 as well as nurse practitioners.

11 It becomes particularly important
12 with the new legislation that was just passed that
13 expects that access to care will improve because of new
14 primary care providers coming on board with mid-level
15 practitioners.

16 And I can tell you that primary
17 care physicians cannot survive on 100% of Medicaid
18 alone, and I'm sure that nurse practitioners cannot
19 survive on 75% of Medicaid. It's just absolutely
20 fiscally impossible. So, we're not going to be able to
21 have the providers to provide the care, that it's going
22 to require all of the other people to be involved.

23 Secondly, a solution be found for
24 the lack of payment for, again, school, sports, pre-
25 surgical physical exams due to the limitation of only

1 one physical exam per year. We believe that these are
2 medically necessary and become an unfunded mandate for
3 the provider who has no choice but to do them. It's
4 unclear at this time how to code these visits anyway.

5 We recommend a meeting between the
6 Physicians TAC, possibly the Nursing TAC, too, to come
7 up with some sort of solution with the MCO's. It's
8 going to require a certain amount of trust between the
9 MCO's and I think the primary care providers because we
10 have to do these. And a letter from the Department had
11 said we consider these not medically necessary, and I
12 would debate that issue.

13 Thirdly, the misassignment of
14 patients continues by the MCO's so that members are
15 assigned to other than their primary care providers
16 causing confusion and access-to-care problems. This has
17 not improved since the inception of managed care, and
18 the MCO's don't seem to understand that there's a
19 problem and how to resolve it. So, we need to also sit
20 down and look at those misassignments. It has not
21 changed and it has not improved.

22 That's the TAC report.

23 CHAIR PARTIN: Thank you.

24 Podiatry Care. Primary Care.

25 MR. DAVID BOLT: I'm David Bolt

1 with the Kentucky Primary Care Association. So, you
2 don't have to take my name off the list. You can put it
3 back on. We have reorganized the TAC.

4 Today I'm representing Chris Kiser
5 who is our new TAC Chair, and I would assume that you
6 all have the minutes of our January 24th meeting in your
7 packet. These are draft minutes. We've not completely
8 gone through those.

9 MS. HUGHES: We do not have those.

10 MR. BOLT: You do not? Well, we
11 got them from the transcriptionist, I was told. So,
12 we'll take care of that.

13 Simply, we are trying to resolve a
14 number of issues related to some longstanding concerns,
15 considering settlement cost reports going back many
16 years, as well as new issues such as reconciliation of
17 Wrap payments and conflicts in some new regulations,
18 especially caps on interim rates which may not take into
19 consideration that a clinic is doing OB and not just
20 outpatient services.

21 We will be scheduling another
22 meeting soon and hope to have the DMS staff involved on
23 some MCO matters as well as some outstanding issues
24 related to our provider groups. We think that will be
25 more beneficial and cause less time and effort on

1 everybody's part and moving forward. We will be
2 scheduling another meeting soon and I hope to report
3 back if we have any recommendations to the TAC.
4 Appreciate your time and have a safe journey home.

5 CHAIR PARTIN: Thank you.
6 Intellectual and Developmental Disabilities.

7 MS. PATTY DEMPSEY: We're back.
8 I'm Patty Dempsey with ARC of Kentucky and I represent
9 the TAC. I'm a representative for the ARC on the TAC.

10 MS. MARY LEE UNDERWOOD: I'm Mary
11 Lee Underwood with the Commonwealth Council on
12 Developmental Disabilities also participating on the
13 TAC.

14 MS. DEMPSEY: And actually we are
15 meeting on a regular basis, and hopefully the committee
16 would have a copy of our last minutes, but we do meet
17 regularly. However, our last meeting had to be
18 postponed because of the weather. So, we have scheduled
19 two meetings, two postponed, but we are scheduled to
20 meet in April, and we'll make sure that a copy of those
21 minutes are distributed as well.

22 But even though we did not meet
23 face to face, we have met on the phone and by emails
24 because there was still a number of issues that needed
25 to be addressed from the TAC group.

1 Our TAC group, the IDD TAC group,
2 of course, is to represent and hear issues and concerns
3 from family members and self-advocates of people with
4 intellectual and developmental disabilities which covers
5 people that are getting Medicaid services such as EPSDT
6 for children and through early periodic screening
7 through regular Medicaid services but also the Waiver
8 services that are for community services.

9 And I think right now in Kentucky,
10 there's probably seven Medicaid Waivers. So, the seven
11 Medicaid Waivers - and I think of those seven, at least
12 probably four of those are probably people that are
13 covered with services with intellectual and
14 developmental disabilities.

15 And, so, some of the issues that
16 we have and that we hear from families and self-
17 advocates is that some of those services can be either
18 traditional services that people can get through
19 providers or they could be through the Self-Directed
20 Option where people that are in the community can hire
21 their own employees. So, that's where a lot of the
22 issues lately that we've had phone calls and emails
23 about have come from. Mary Lee is going to talk about
24 that.

25 But some of our previous concerns

1 that we talked about were the Supports for Community
2 Living Waiver, and some of those deal with the budgets
3 that people have when they do self-direct their
4 services. And there is usually a lapse in services
5 because a person or a family member, for them to be able
6 to continue their budget each year, even though there's
7 no changes and continuation in those services maybe just
8 for the people they hire, even though there's no changes
9 in those services - and some of these people have been
10 getting those services that are now 60 years old that
11 are living with guardians and living with family members
12 - they still have to go through a process every year and
13 be reassessed and do a new budget every year.

14 And one of our suggestions that
15 we've talked about at our past meetings is that maybe
16 the Cabinet look at a continuation budget for those
17 people that do not have any changes so that there
18 wouldn't be any lapse of service and that that backlog
19 there would be--there wouldn't be interruption and would
20 help with the backlog. So, that's one of the issues we
21 wanted to address.

22 And, then, another is the EPSDT
23 services. And a lot of the EPSDT services for some kids
24 that are were the Michelle P. Waiver are now being moved
25 over to regular Medicaid for EPSDT services and they're

1 having trouble finding providers. So, some of those
2 families are not getting services right now. So, that's
3 one of the issues we'd like to see addressed as well.

4 And, then, another one of the
5 issues has to do with people that are getting services
6 under the Self-Directed services now are going to have
7 to start paying for background checks, and I'm going to
8 turn that over to Mary Lee because she's going to talk a
9 little bit about that.

10 MS. UNDERWOOD: Thank you, Patty.
11 Yes. It's come to our attention - and I guess this is
12 by way of planting a seed for your consideration because
13 I understand that you want the recommendations in
14 writing.

15 However, many consumers that we
16 deal with are very concerned that in order for the Self-
17 Directed Option to have meaning, their budgets to be
18 able to include those things that they are required by
19 law to do. One of those things that they're required to
20 do now is ensure that their employees have specific
21 training and that there be a number of specific
22 background checks run.

23 The projected cost of those
24 trainings and background checks is \$372 per employee.
25 Some people have as many as ten employees to provide

1 their daily personal care and the support that they
2 need. So, 372 times 10 is \$3,700 or so for an
3 individual whose income is limited to SSI and relies on
4 Medicaid to supplement that to provide for their medical
5 needs. That's really a cost that they can't afford to
6 incur.

7 And you think about the high
8 turnover in the field of people providing personal care
9 services, that number can really escalate. One person
10 who spoke to me about this said that over the last five
11 years, she had employed eighty different people. We can
12 all do the math and understand that that is going to be
13 astronomical for folks who are on very, very limited
14 incomes.

15 So, I think that that will be one
16 of the recommendations that's forthcoming is that those
17 budgets either be expanded or at the very least that
18 individuals be able to include that as a line item in
19 their budget and use the funds that they receive through
20 their Medicaid Waiver to meet the requirements of the
21 Waiver.

22 MS. DEMPSEY: And I think that's
23 it.

24 CHAIR PARTIN: Thank you very
25 much.

1 MS. HUGHES: And I don't have your
2 written comments either.

3 MS. DEMPSEY: We'll get them to
4 you.

5 COMMISSIONER KISSNER: Just to be
6 clear, a TAC can't meet on email and can't meet on the
7 phone. That's against the law. I just want to be
8 clear. We have an Open Records Law that says the TAC--
9 that's what they talked about earlier up there.

10 You really don't have a meeting
11 until you have a public announcement that says we're
12 having the meeting on this date at this place and you
13 allow for people to come if they want to come because
14 they have to be open meetings. So, you need an official
15 meeting because otherwise you would be saying, well,
16 here's some information. We didn't have a meeting, so,
17 I'm giving you the proof that we violated the law.

18 MS. DEMPSEY: We don't want to do
19 that. That's why we don't have written recommendations.

20 COMMISSIONER KISSNER: Good. So,
21 I just want to be clear----

22 MS. DEMPSEY: We've had
23 conversations, not meetings.

24 COMMISSIONER KISSNER: ----to have
25 official meetings, set it up, invite people, open

1 records, do it right.

2 MS. DEMPSEY: Thank you very much.
3 And that's why we don't have a written report. Thank
4 you. We do appreciate it. But we did want to come
5 today and let this group know that we do meet and that
6 we're scheduled to meet at the end of April. We did not
7 meet because it snowed. We had to cancel, but thank
8 you.

9 MS. ENNIS: Can I clarify? The
10 meeting can be posted and there are people present but
11 can you also have people on the phone attending as well?

12 COMMISSIONER KISSNER: Sure, as
13 long as you have enough lines for people. If they say I
14 want to participate but I'm going to be online, we've
15 done that I think with the MAC.

16 MS. UNDERWOOD: Actually, you
17 might want to review the open records' laws. I'm pretty
18 sure they require video conferencing, not just
19 telephone. Unless there's been some change in the law
20 in the last couple of years, that's how they were
21 originally drafted was for video conferencing.

22 CHAIR PARTIN: The Board of
23 Nursing I know does just the teleconferencing.

24 MS. UNDERWOOD: The Office of the
25 Attorney General would be the expert to consult on that.

1 They have a division that works on that.

2 CHAIR PARTIN: So, I'd like to
3 have a motion to approve all of the recommendations from
4 the TAC reports.

5 MR. VAN LAHR: So moved.

6 CHAIR PARTIN: Second?

7 DR. RILEY: Second.

8 CHAIR PARTIN: All in favor say
9 aye.

10 MR. CARLE: Beth, could I have just
11 a little discussion first?

12 CHAIR PARTIN: Yes.

13 MR. CARLE: I just want to state
14 specifically for the record that the Hospital TAC would
15 like a recommendation from the MAC that the Cabinet
16 delay the amendment of their DRG's and updated grouper
17 given the fact that the ICD-10's from a federal
18 perspective are being suspended until we can work out
19 some of the issues that have been presented by Nancy and
20 Carl because it wasn't written as a specific
21 recommendation, but it is in the body of the testimony
22 that was presented by Carl and by Nancy.

23 CHAIR PARTIN: And it was also
24 about the hospital reimbursement----

25 MR. CARLE: The out-of-state

1 charges, correct.

2 CHAIR PARTIN: So, those are two
3 separate recommendations.

4 MR. CARLE: Yes.

5 CHAIR PARTIN: Okay. So noted.
6 Anything else? All in favor. Opposed. So moved.

7 Under New Business, actually,
8 we've addressed one of those--well, we've actually
9 addressed both of those, I think, in the TAC reports.
10 So, I don't think we need to say any more about that.

11 Are there any other issues that
12 anybody would like to bring forward?

13 MR. FOLEY: Just one quick comment
14 just to get an answer. It seems that some of the TAC's
15 have recommendations and they're not getting responses.
16 It's the Cabinet's intent to respond to all the
17 recommendations that come through the committee, right,
18 to each of the individual TAC's?

19 MR. WISE: Right, when they're
20 sent to Sharley and we have the minutes, yes.

21 MR. FOLEY: It sounded like some
22 aren't getting answers to some of them. So, that's why
23 I was just curious.

24 CHAIR PARTIN: I've been trying to
25 include that in our Old Business when we don't get a

1 response.

2 MR. FOLEY: Or some are saying
3 it's been a year. They keep saying the same thing.

4 MR. CARLE: Which is why I wanted
5 it specifically in the record.

6 MR. VAN LAHR: Madam Chair, since
7 this will be hopefully the last time we'll have a
8 meeting without a Pharmacy TAC, a couple of comments I
9 would like to make as far as pharmacy is concerned we're
10 trying to deal with.

11 One, in the last probably three or
12 four months, we're having a lot of problem in the retail
13 sector with emergency room docs or residents who are not
14 Medicaid-approved providers with prescriptions. And
15 since we're the only ones who do things on a realtime
16 basis, if a patient presents with a prescription from a
17 non-Medicaid provider, we're just kind of screwed. I
18 mean, there's no recourse. If you want to try and call
19 the hospital clinic on a Saturday or Sunday afternoon
20 and get something, there's no alternative.

21 And, so, I would ask that DMS look
22 for some kind of provision or an emergency provision for
23 pharmacies to grant a three- or four-day supply until we
24 can contact the provider or get somebody else to write
25 the prescription for that patient because that is a

1 problem for us in the retail sector in providing direct
2 patient care.

3 Along that same line, it would be
4 really great because usually as far as a pharmacy or a
5 drug preauthorization, those usually originate from the
6 pharmacy to the provider, to the physician or APRN. The
7 problem with that is we don't get notice at the pharmacy
8 level whether it's been approved or denied.

9 And I would request that DMS
10 encourage the MCO's through their PBM's to in that
11 process provide notice to the pharmacy whether a
12 preauthorization for a medication has been approved or
13 denied in addition to the provider because what happens
14 is if the patient comes in to the pharmacy and says I
15 got a call from my doc that it's been approved, well, I
16 don't have anything on it.

17 And it creates kind of a logjam
18 sometimes in the pharmacy trying to find out was it
19 approved, what drug, what quantity, all those pieces.
20 We don't know that. So, I would ask that there be some
21 provision in that process to be notified at the pharmacy
22 level of preauthorizations.

23 Last, and I think this has been
24 addressed somewhat in various and sundry ways. With the
25 multiple MCO's/PBM's we deal with at the pharmacy level,

1 there is a tremendous lack of consistency on drugs which
2 are covered by an individual PBM at the pharmacy level.
3 And as I have asked previously to have pharmacy
4 separated out, the patient may choose a provider based
5 on their needs; but that provider may not have the best
6 drug coverage for that particular patient available.

7 And, so, I would encourage that we
8 need to have some either more uniformity of drug
9 coverage or some provision - and as I've asked before to
10 have pharmacy spun out and a patient could choose a -
11 and I'm not going to get that, I understand that - but
12 if they could have the ability to choose based on their
13 medication needs sometimes.

14 My last request is that at the
15 point in time we do have - and, by the way, I think it's
16 been approved by the Legislature and I think maybe even
17 signed by the Governor that we will have a Pharmacy TAC
18 again - that Medicaid Services either ask/require the
19 PBM's, not the MCO's, but the PBM's to be in attendance
20 or available for the Pharmacy TAC meetings since they
21 are the only ones who can answer those questions that we
22 have on a pharmacy level, not the MCO's.

23 That's it. Thank you, guys.

24 CHAIR PARTIN: Thank you.

25 Anything else?

1 DR. WATKINS: Beth, is this where
2 I needed to add my recommendations that we were saying
3 was not to be addressed in Old Business?

4 CHAIR PARTIN: Actually, I thought
5 you could do it under the TAC but apparently you
6 couldn't. So, yes, go ahead so we have a formal record
7 and we can ask for the response.

8 DR. WATKINS: So, the
9 recommendations that the optometrists were asking for is
10 that the benefits are not to be cut to the patients and
11 it be restated that they can receive one eye exam per
12 provider per year.

13 And please make it so that there
14 also would be a recommendation that there be a way
15 online to verify that that person is eligible for an eye
16 exam at that point in time.

17 If there's going to be
18 restrictions if that person is eligible for an eye exam
19 if it's been a year since they had had it, because from
20 the way that the new regs are reading, they're going to
21 be moving from a calendar year to a 12-consecutive-month
22 period; and if the person has seen another provider, we
23 have no idea of whether we're going to get paid for that
24 exam or not. We're recommending there be a way to
25 verify the eligibility online,

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And, then, the third thing would be that optometrists are defined in the regulations under the Optometric Practice Act which is KRS 320. In the regulations, it cited the Physicians Practice Act which is vague as compared to the Optometric Practice Act which is what we have been defined under in the past. Thank you.

CHAIR PARTIN: And would you write those out so Sharley has them?

DR. WATKINS: Certainly.

CHAIR PARTIN: Thank you very much. Anything else?

MS. SHARLEY: Just for Sharon, 907 KAR - this is your private duty nursing reimbursement - 907 KAR 13:015.

CHAIR PARTIN: Anything else?
Motion to adjourn.

MS. BRANHAM: So moved.

CHAIR PARTIN: See you all next time.

MEETING ADJOURNED

STATE OF KENTUCKY

COUNTY OF FRANKLIN

I, Terri H. Pelosi, a notary public in and for the state and county aforesaid, do hereby certify that the foregoing pages are a true, correct and complete transcript of the proceeding taken down by me in the above-styled matter taken at the time and place set out in the caption hereof; that said proceedings were 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 7th day of April, 2014.

Notary Public
State of Kentucky at Large

My commission expires February 10, 2017.