CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

January 25, 2018
10:00 A.M.
Room 125
Capitol Annex
Frankfort, Kentucky

MEETING

APPEARANCES

Elizabeth Partin
CHAIR

Susie Riley
Chris Carle
Julie Spivey
Stacey Watkins
Ashima Gupta
Steven Compton
Gary Marsh
Melody Stafford
Jay Trumbo
William Schult
Sheila M. Currans
Teresa Aldridge
Jerry Roberts
Susan Stewart
COUNCIL MEMBERS PRESENT

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AGENDA

CHAIR PARTIN: We will go ahead and call the meeting to order and we do have a quorum. So, first up on the agenda is approval of the minutes for the November meeting. Would somebody like to make a motion to approve those?

MS. STAFFORD: Motion to approve.

CHAIR PARTIN: Melody. Second?

MR. CARLE: I'll second.

CHAIR PARTIN: Chris. All in favor, say aye. Opposed? Minutes are approved.

We'll move along to Old Business. First up is an update on the Hepatitis C, and we did get a handout this afternoon on that.

DR. McKINLEY: Good afternoon. I am Samantha McKinley, Pharmacy Director for Kentucky DMS.

MR. LIU: Good afternoon. Gil Liu, Chief Medical Officer, Kentucky Medicaid.

DR. McKINLEY: So, our item on the agenda is the Hep C update. And the last time we had the opportunity to meet and chat about Hep C, I was telling you about where we were forging in the Department with our fee-for-service benefit and said I would put together a summary.

We have been working on that. Sharley, I believe, handed out sort of an update list for you. I thought that that would be helpful for today.

So, it starts with sort of the time line. Remember I talked about pricing last time we were here. Our pricing was officially in place in October of 2017 on the new drugs that came out. November of 2017 is when our fee-for-service benefit revised the Hep C class criteria, and our new criteria was also adopted by our P&T Committee and then final decision signed by the Commissioner, and December of 2017 is when the final decisions were formally filed and stamped for approval.

So, pricing has been in effect since October for us and then criteria since November. And I wanted to kind of give you sort of the outlay of the major changes in the criteria from where we were when we met last time.

So, currently for the fee-for-service benefit, we have eliminated any relation to the disease severity or the up-score which was a pretty big hurdle for a lot of folks to come forth and get treated at the time.

We also eliminated the sobriety

requirement both in its relationship to alcohol as well as substance use disorders.

We lessened the laboratory submission requirements. I listed those out for you. I will let you read those. I was just trying to really get the high points for you.

And, then, also with the PCP provider ability to treat, we still want a specialist. However, we have relaxed some of that requirement so that a PCP can actually work with a specialist in areas where that's necessary because it's just easier for transportation or other means for the member.

And, then, I listed some others. Still the universal PA authorization form. All these drugs still require a prior auth, however, that universal form is up and running across the board with all of the MCOs and fee-for-service. So, that does apply.

And, then, if you look on the back of this sheet, I just wanted to give you an update because I told you that my goal was to get alignment with all of the Managed Care Organization health partners that we have across the state, and, so, I just wanted to sh ow you where I was on that.

Aetna came on board with us in November of 2017. And what I mean on board, that means they've adopted the clinical criteria that we're using. So, we're very much aligned in that way.

Anthem is set to on board February 1st actually, so, just in a couple of weeks.

And, then, Humana-CareSource, Passport and WellCare are not really having any barriers to coming on board, however, it needs to run through their Pharmacy and Therapeutics Committee in March. So, the expectation there is by April 1st of 2018.

So, I'm hoping that by spring, April 1, we have everyone aligned with the criteria so we'll have universal Hep C criteria across the state with a universal PA form, and I'm hoping that that alleviates a lot of the burdensome that there was placed on providers and also opens up access to treat this disease state.

And I think, Dr. Liu, you wanted to say a few things about this.

DR. LIU: I think in general, everybody feels very positive about the liberalizing of criteria to allow more access to treatment for

Hepatitis C.

I would remind everyone that that is in the context of a very costly therapy. So, the reasons for the prior restraints requiring evidence of more severe, chronic disease and a feeling that those whose Hepatitis C infection was complicated by substance use disorder were having that behavioral health need addressed as well so that you wouldn't have a patient potentially not adhere to therapy or, even worse, require a pretreatment.

Those are concerns in the face of wider access. So, I wanted to offer to you a set of dashboards that look at the rates of testing, the rates of diagnosing, the rates of treatment. We'll be proactively looking at the request for authorization, the granting of authorization, the denial of treatment.

Furthermore, I would remind you that we did have a focus study by an independent evaluator of Hepatitis C treatment. Through that study, we're allowed to benchmark our treatment rates against other states, and it identified a few areas of concern that we're going to be proactively addressing.

One of those is that there is

interesting treatment rate differences by race ethnicity. African-Americans in general were significantly being treated at lower rates than people who are not African-American. Pregnant women can transmit this disease during their pregnancy to their children and we want to be sure that women in pregnancy are screened and treated.

One particular vexing thing about requiring an advanced fibrosis score is that delayed treatment for pediatric populations and that was something that needed to be urgently addressed. So, now we feel comfortable that pediatric populations have a very rapid entryway to treatment.

The last thing is Hepatitis C is often a comorbidity of IV drug abuse, and I'm glad to report that we're partnering very closely with agencies like our Department of Public Health.

Kentucky has been recognized as being very successful and progressive in terms of offering things like syringe exchange programs, trying to promote immunization against other forms of hepatitis and in general looking at how we work along with other agencies, Corrections, to be thoughtful about how we take a comprehensive approach to hopefully eradicating this eventually.

So, I just wanted to assure you that we're appealing to data. We've weighed the pros and cons. We have special subgroups that we're going to be focusing on going forward.

And, lastly, just this week, we met again with kind of treatment champions for Hepatitis C. Representatives were here from both of the university academic centers, large health care systems, just reexploring with them how do we better integrate behavioral health services with infectious disease specialists or gastroenterologists, how do we make sure that we're getting high quality, comprehensive care in the face of a very costly treatment proposition.

DR. McKINLEY: Any questions?

CHAIR PARTIN: It doesn't look like it. Thank you very much.

MR. CARLE: This is just a comment. Thank you very much for the work that you did on making this happen. Very appreciative to everybody's work collectively.

DR. McKINLEY: Thank you.

CHAIR PARTIN: Next up on the agenda are the MAC bylaws, and you all in your folders should have a copy of the draft that the

subcommittee worked on and also a copy of the draft that Sharley sent us with some suggested changes.

And, so, I thought just to give everybody an opportunity to speak and to consider all of the sections, we would just go section by section. And, then, anybody who has comments or questions or suggestions, we can offer them in each section.

So, let's start out with Number I which is the Purpose, and there was just one editorial suggestion there that Sharley had. Otherwise, it's pretty much the way the committee had recommended it.

So, is everybody good with that, adding the word "to" before advise in that first sentence? Yes? Okay.

And, then, moving on to Section II, Duties of the MAC, and, again, I guess I should go to the very top. We should use the Advisory Council for Medical Assistance because that's the way it is stated in the law. And, so, we should use that rather than our shorthand MAC.

And, so, that would follow through in Section II where we wouldn't say Duties of the MAC. We would say Duties of the Council.

And, then, in that one, there

was just one typo. The word serious, it was misspelled in that last sentence, the second to last word.

Does anybody have any other comments on that? No? Okay.

Then, let's move on to Membership, Number III. It was suggested again - I don't think this makes any significant difference - Effective as of the date of these bylaws, adding that to the first sentence for membership.

MS. ALDRIDGE: Dr. Partin, Kentucky Equipment Suppliers Association needs the word Medical. It's Kentucky Medical Equipment Suppliers Association.

CHAIR PARTIN: Okay. Thank you. So, on Sharley's copy, it's at the top, the top one. So, we will say Kentucky Medical Equipment Suppliers Association. I think that's all there.

Then Terms of membership. It's B, and there's some suggestions here for amending it. I know that all of the Council members were very frustrated at a point in time when we didn't have good attendance and we didn't have adequate numbers appointed to the Council.

And, so, it was very difficult

to have a quorum for our meetings and to get any meaningful work done. And out of that frustration came these suggestions from the subcommittee about if a person doesn't attend the meetings, that they would basically be terminated essentially is what this says.

The attorney with DMS had talked with the subcommittee and had advised that the Council doesn't have the authority to remove any members from the Council, that it is totally up to the Governor to appoint members, and, therefore, the Council has no authority to remove members.

And having said that, we need to delete Number 2, 3 and 4 from the draft that the subcommittee sent out, not that I don't understand totally the frustration because I lived through it, but legally we don't have any authority to do that.

And, so, I welcome any discussion on that.

MR. CARLE: Beth, in looking at this again, in Number 2, obviously we say that their position shall be deemed vacant and result in an appointment by the Governor of another individual to fill the vacancy.

Why can't we just amend this to

say that we would recommend to the Governor that that individual be terminated and the process for a replacement to be started as soon as possible.

CHAIR PARTIN: Okay.

MR. CARLE: And I think that the attorney for DMS would--it puts the power back in the Governor's hand but we have set forth the precedent that we will make that recommendation in the event that the individual fails to attend at least 50% of the meetings which is really the teeth, if you would, that we want to have set forth in this document because, otherwise, you notice today, most of the people in here cheered when we said we had a quorum.

So, I just make that recommendation if it meets the needs of DMS.

CHAIR PARTIN: Okay. What about the rest of the Council? Comments?

MR. TRUMBO: Agreed.

CHAIR PARTIN: You all agree? Okay.

DR. SPIVEY: In doing that, do we need to spell out how we would alert the Governor?

CHAIR PARTIN: We would just need to say that we would do it, I guess.

DR. SPIVEY: Just notification.

MR. CARLE: It would come from the Chair, via the liaison. I wasn't trying to cut you out of anything, Sharley.

MS. HUGHES: Oh, no.

MR. CARLE: You gave me that dagger look that you have.

MS. HUGHES: No, I didn't know I did.

MR. CARLE: I'm just joking.

CHAIR PARTIN: So, the new wording would say: If a member fails to attend at least 50% of the MAC meetings in a calendar year or misses two consecutive meetings in a calendar year----

MR. CARLE: Notification would be provided to the Governor.

CHAIR PARTIN: Notification will be provided to the Governor.

MR. CARLE: And a recommendation of termination. Now, the Governor's Office can do whatever the Governor's Office would like to do but that at least puts the process in motion and the request for a replacement would occur as well. We'll jet Jay wordsmith it. He was good at

that or Julie.

CHAIR PARTIN: Okay. Do we want to leave in, then, absences may be excused under extenuating circumstances? Do you want to leave that in? Okay.

And, then, if absences have not been excused, the Chairperson shall notify the MAC members if a member has missed more than 50% of meetings or two consecutive meetings in a calendar year. Do we want to keep that?

MR. CARLE: Yes.

CHAIR PARTIN: Yes? Okay. We'll have to delete Number 4: Following notification of the MAC, the member shall be notified that the position is deemed vacant. So, we have to take that one out.

MR. TRUMBO: Or could you change the wording of that to just notify them that a letter is being sent to the Governor requesting that their position be replaced?

CHAIR PARTIN: So, following notification of the MAC, the member shall be notified that a letter has been sent to the Governor notifying him?

MR. TRUMBO: Requesting that

their position be replaced.

CHAIR PARTIN: Okay.

MR. SCHULT: And going back to to 2(a) where it ends with allowing the individual to continue to serve, I think that implies that we make the decision of who can and can't serve when it's ultimately the Governor. So, perhaps better wording would be a joint decision of the Chair, Vice-Chair and Secretary foregoing sending notification to the Governor.

CHAIR PARTIN: You're speaking about Number 2?

MR. CARLE: 2(a).

MS. HUGHES: That's the second bullet, right?

MR. SCHULT: Right.

CHAIR PARTIN: Could you say that again, please?

MR. SCHULT: Just instead of allowing the individual to continue to serve on the MAC, just put a joint decision of the Chair, Vice-Chair and Secretary to not send notification to the Governor of their absences due to the circumstances.

CHAIR PARTIN: Okay. Anything else under Terms of membership?

DR. GUPTA: Actually going back up to Membership, Section A, I just looked it up and I think Kentucky State Medical Association, it looks like it's just KMA, Kentucky Medical Association, as far as what I can tell.

CHAIR PARTIN: In the statute?

DR. GUPTA: No. Instead of saying Kentucky State Medical Association, I think it's just Kentucky Medical Association.

CHAIR PARTIN: That's the way it's worded in the statute.

DR. GUPTA: Okay. I just looked it up. I just wanted to make that comment.

CHAIR PARTIN: Looked up what, in the statute?

DR. GUPTA: No. I looked it up online.

CHAIR PARTIN: I think in the statute, it's worded that way. So, that's why we listed it that way.

Member Responsibilities. There was a suggestion to add Members are expected to be present at all scheduled meetings. That's on Number 1. Is that okay with everybody? Yes? Anything else under Member Responsibilities?

Then, going to MAC Officers, and, again, we wouldn't way MAC. It would have to be the Medicaid Advisory Council. We had in there under Role of the chair, Number 3, for submission of the agenda, we had one week and it's suggested adding two weeks.

I think the one week was in there because things happen quickly and things are happening up to the last minute. And, so, in order to have the most up-to-date information in the agenda, the one week was put in there.

And I understand from DMS' point of view, two weeks helps them to get ready for the meeting and to know what we want to talk about, but perhaps we don't know everything that we want to talk about two weeks before the meeting.

So, can we have some discussion on that? What do you all think?

MR. TRUMBO: If you're wanting there to be discussion on their side, they need adequate notice. You could raise the topic and then assume that we'll follow it up on the next scheduled meeting if it's not enough time for them to research the topic.

DR. RILEY: I think you could

have the initial notice two weeks with revisions occurring up until what's comfortable.

CHAIR PARTIN: Okay. That sounds fair. What do you think of that? Okay. So, initial draft two weeks with revisions coming up to one week.

DR. RILEY: Yes.

CHAIR PARTIN: Anything else in that section under officers' roles?

Then, let's go to the role of the members. Anything there? We're all good? Okay.

And, then, the next section is the role of DMS. And probably if we're going to say Medicaid Advisory Council, we should probably say Department of Medicaid Services as well rather than DMS.

Under the role of DMS, there was a suggestion to just say that the recommendations from DMS should come back to the MAC in a timely manner. The subcommittee thought thirty days because it gives the Council an opportunity to think about and form any responses that we want to make to the responses from DMS.

And, so, when they come back three days before the meeting, that really doesn't

give us much opportunity to read them, much less think about them.

So, my recommendation would be to keep the thirty days but I'd like to hear from the Council and your thoughts.

MS. ALDRIDGE: If you leave it at timely manner, it looks like it's not giving them a definitive time. It's leaving it wide open. So, I agree with you.

CHAIR PARTIN: Right.

MR. SCHULT: I mean, I agree with putting in some specific timing. If thirty days is too soon, maybe we stick with the other timing of the two weeks before the next meeting which is roughly forty-five days, but I think definitely putting a number of days in there or a specific date is a good idea.

MR. CARLE: Since it's forty-five days, why don't we just compromise and make it forty-five days.

CHAIR PARTIN: I'm okay with forty-five days. So, we'll compromise at forty-five days. Anything else under that section?

Then, next is Operating Procedures. And in Number 1, there's just a typo.

It should be notice, at the discretion of the MAC Chair and not as. Anything else under the Operating Procedures? We're all good with that? Yes? Okay.

Then the next section is Bylaws. So, there's a suggestion to add Number 5 the that would say that the bylaws shall be reviewed and approved by DMS to ensure that all the bylaws are in accordance with both federal and state laws and Medicaid policies and procedures.

I would like to recommend that we not be required to have the bylaws approved by DMS because I think it's clear in the statute that the Council is supposed to prepare its own rules, and there's nothing in the statute that requires approval by DMS.

I think certainly it's important that the bylaws are prepared in accordance with federal and state laws and that we should be advised by DMS that we follow those things; and if we're proposing something that is outside the law, then, we should be advised of that and we should take heed; but as far as having them approved, I would recommend that we remove that requirement.

So, discussion? I'm seeing heads nodding but nothing verbal for the recorder.

DR. RILEY: Are you saying that you would leave reviewed but just remove the word approved?

CHAIR PARTIN: I would say DMS may offer advice to assure the bylaws are in accordance with federal and state laws.

MR. SCHULT: Great.

MR. TRUMBO: If you struck and approved, would that suffice for what you're trying to do?

MR. CARLE: It will be the bylaws shall be reviewed by DMS and strike and approved.

CHAIR PARTIN: That would work. Did everybody hear that? The suggestion was just to remove the words and approved. Yes? Okay.

And, then, under Subcommittees, there was a suggestion to add: The subcommittee lead member will report subcommittee findings and recommendations to the full MAC for their information and action. So, are we all okay with that? Okay.

Next is the Technical Advisory Committees, and the first suggestion is to add the wording under B: As of the effective date of these bylaws.

MS. HUGHES: Beth, the reason I put that language in is because I think it said you had to review the bylaws every other year, that if the Legislature changes, say, for instance, either the TAC or the MAC member list, then, you wouldn't have to change--with a list of each of them, you wouldn't necessarily have to go back and make a revision back to the bylaws until the next time you normally would do it.

MS. ALDRIDGE: A good example, Dr. Partin, is this is the first time DME has ever been represented on the MAC and we have no TAC for DME. We're listed under Home Health which is totally different than what DME is.

So, we're in the process with Brandon Smith as the Legislature liaison and he's working on getting a DME TAC. It has to be appointed through legislation.

So, with that wording, that will allow, as Sharley said, that we wouldn't have to revise the bylaws.

CHAIR PARTIN: Right. So, are we all okay with that? Okay.

Then, moving down to----

MR. CARLE: There's another

change above that, Beth.

CHAIR PARTIN: Okay. So, the suggestion was to remove under A, under Technical Advisory Committees, there are fifteen. Instead, it would say: Pursuant to KRS 205.590, Technical Advisory Committees were established and just leave out there are fifteen, and that, I think, goes to Sharley's explanation.

Then, under C, this would say that the TAC Chair shall notify DMS Commissioner and the MAC liaison of appointments and shall fill vacancies, as they occur, to ensure a quorum. So, that's just saying that the Chair of the TAC is going to notify the Commissioner, and, then, it's adding that will also notify the MAC liaison.

And, then, D is remaining the same. There's no suggestions for changing that.

And, then, the next one, on the draft from the subcommittee, the recommendation is that the TAC would make recommendations to the MAC at the meeting and the MAC would accept the TAC recommendations for action and the MAC would not be required to have a quorum in order to accept TAC recommendations if the TAC recommendations were approved at a TAC meeting with a quorum.

And, then, again, DMS shall respond to TAC recommendations within thirty days, and we've just agreed that it would be forty-five.

So, in the draft that Sharley sent us, that section is removed and instead it's saying that the TAC would have to have a quorum in order to approve the TAC recommendations.

My thinking on that is that right now we have adequate members and it would be fairly easy to have a quorum to accept or approve the recommendations from the TACs.

But the bylaws that we're writing are also looking towards the future, and who knows what it's going to be four years from now when people are going off, their appointments are expiring and we may end up in the same boat that we were in before, depending on how fast people are reappointed when their terms expire.

MS. HUGHES: Beth, even if their term expires, for instance, I think you were just recently reappointed. So, in four years, when your term expires, you continue to serve until you're either reappointed or someone is appointed for you.

CHAIR PARTIN: Right.

MS. HUGHES: So, I think you're

still going to not have it----

CHAIR PARTIN: I understand that and that's how it's supposed to work but that's how it didn't work for several years.

MS. HUGHES: Because we had quite a few actually resign.

CHAIR PARTIN: People resigned. So, in best-of-all worlds, that's how it works, but in reality maybe not.

The way I look at it in any case is that we're not approving the recommendations from the TAC. The TAC has already approved their recommendations. What we are doing is we are accepting their recommendations.

And, so, therefore, I think that because of all the things that I've said, that it's more reasonable that the TAC should have their quorum when they're making their recommendations and that it's not required that the MAC have a quorum in order to accept the recommendations, but I would like discussion from the Council.

MS. STEWART: I agree with you.

MS. GUPTA: I agree with you, too, Beth.

DR. SPIVEY: So, if we change

that, I was looking back at this, we're going to have to go back to H, Number 5, and change that, the role of the members, because they go together because it talks about voting. You're talking about not voting, correct? It's talking about voting on the TAC recommendations. So, we would have to change that wording. Does that make sense what I'm saying?

CHAIR PARTIN: Well, we could still vote on them. We just don't have to have a quorum to vote on them.

DR. SPIVEY: Okay. So, that would stand and, then, we would just say when we vote, we don't have to have a quorum. Okay.

CHAIR PARTIN: So, where are we? Does anybody disagree with keeping it the way the subcommittee suggested?

MR. TRUMBO: Is the wording that's there now what we are recommending?

CHAIR PARTIN: What I'm recommending is that we keep the wording as the subcommittee submitted, not the amended language that Sharley sent to us. I think I read it already. Does everybody have both copies? Yes, we do. Sharley gave it to us.

MS. STEWART: Dr. Partin, we'll

have to change 2 as well to say forty-five days.

CHAIR PARTIN: Yes. We would change that, Number 2, to forty-five days. So, we're all in agreement with that? Okay.

Then, each TAC shall elect a Chair and a Vice-Chair and that election shall be held in each state fiscal year (July 1st) when a quorum is present. That stays the same.

DR. RILEY: Beth, that's not one of the items for correction; however, that is not currently how our TAC is operating. Our Chair is appointed for a three-year term. So, does that mean that each TAC will need to be in alignment with this recommendation?

CHAIR PARTIN: It would if we accepted it. We can change it. We can just say each TAC shall elect a Chair and Vice-Chair.

DR. RILEY: That works.

MR. CARLE: And strike the rest.

CHAIR PARTIN: So, we'll strike the rest about the election.

This is referring to a majority of the members of the TAC must be present in order to approve their recommendations. Am I reading that

right?

MS. HUGHES: Yes.

CHAIR PARTIN: Are we okay with adding that?

MR. TRUMBO: Question. On the vide conference, what are we trying to achieve with that?

MS. HUGHES: State law actually requires that you can't use a telephone to call in. You have to actually be able to basically be present. So, like, if you wanted to call in, everyone would have to be able to see you to see that you were attending. So, they can't just call in on their cell phone and have that count towards their quorum.

MR. TRUMBO: Do we have that technology?

MS. HUGHES: I know a couple of the TACs do, the actual TAC member. I think the Chair - I don't know if Beth Ennis is here - I think the Chair of the Therapy TAC does have equipment and they do it. I don't attend the TAC meetings, so, I don't know if any of the others do by video conference, but there is an actual room scheduled for each TAC meeting so that the public can come; but in order for them to have a quorum, they would have to

be either visibly sitting at the table or be seen on video conference. I think we got a clarification from the Attorney General last year on that.

MR. TRUMBO: Okay.

DR. GUPTA: And, Sharley, to make quorum, the majority of the members must be present or on video?

MS. HUGHES: Yes. So, if you've got five people on your TAC, then, you would have to have three people present.

DR. GUPTA: And, then, as far as electing the Chair and Vice-Chair, if we're removing the wording of having an election every July - we're taking that out, right?

CHAIR PARTIN: Yes.

DR. GUPTA: So, then, that means that the Chair and Vice-Chair can just be there as long as----

CHAIR PARTIN: Each TAC will elect a Chair and a Vice-Chair. So, the TAC can choose how they're going to do that.

DR. GUPTA: And how long that term lasts?

CHAIR PARTIN: Yes. So, we're okay with that, about the quorum, right? Yes? Okay.

So, the next one is the TAC Chair or a member of the TAC appointed by the Chair shall present the TAC recommendations to the MAC. The recommendations of the TAC shall not be presented by anyone not appointed to the TAC. Are we okay with that?

Non-appointed individuals may make a request of the TAC Chair to speak at a TAC meeting but may not vote, conduct the meeting or represent the TAC at MAC meetings. These duties may only be done by appointed members of the TAC. We've got that in the recommendations from our subcommittee.

The next one is a suggestion that at the last meeting of the calendar year, the TAC shall set the meeting schedule for the following year and shall notify the DMS TAC liaison to ensure the meeting notices are posted on the website.

I don't think that all of the TACs function that way. So, I would instead suggest that the TAC shall notify DMS liaison of a meeting date at least thirty days prior to the meeting to ensure the meeting notices are posted on the website. Yes? Okay.

The next suggestion is members

may not speak publicly on behalf of the TAC without prior permission from the Chairperson and only in accordance with the majority vote of the members at the TAC meeting.

MS. HUGHES: These last three are in the MAC recommendations. So, I just kind of carried them over to the TAC.

CHAIR PARTIN: Are we okay with all those? Yes? Okay.

And that's it. So, we have gone through the whole document and made our suggestions for revisions and approved each section as we went along.

Would somebody like to make a motion to accept these bylaws as we have just discussed and amended?

DR. RILEY: So moved.

MR. TRUMBO: Second.

CHAIR PARTIN: Dr. Riley and Jay. Any further discussion? All in favor, say aye. Opposed? We have bylaws. And this is as first, you know. We've never had bylaws. So, this was a real big accomplishment.

Next on the agenda is some questions - I think Jay wanted to discuss this -

insurance liability and expenses for nursing homes. Is that right?

MR. TRUMBO: Yes. I was hoping Commissioner Miller could give us some updates or insights based upon the concerns that we had expressed at the last MAC.

COMMISSIONER MILLER: Good afternoon, everyone. Steve Miller, Medicaid Commissioner, but I think everybody already knows that, and I'll address those questions and then we'll get into more of a report.

As it relates to what we had chatted about at the last meeting, what you had brought forward, Jay, as it relates to the additional expense liability that nursing homes and others are running into and, in fact, sent me a report that basically had it broken down by state, and I clearly understand that and the increased cost that you are incurring, like many other providers are incurring, whether or not it is for increased insurance costs or just other operating costs, but in order to do something there, it obviously takes dollars in my budget. It's just kind of that simple.

You know what increase you have gotten being minimal over the last couple of years,

three years, whatever that time frame is, as compared to where a number of other providers have not gotten any.

As it relates to the budget, and I'll just address some of that right now, is the fact that the proposed budget starting 7/1 of '18, for lack of a better term, for Medicaid is a bare-bone, sustained budget, and going forward, kind of a baseline only.

There, as in the Medicaid budget, always looks like big dollars just by the nature of looking at an overall $11 billion program; but the dollar increase, the Department's increased spend over the next two years only covers the increased costs associated with what I will call the ACA requirements.

And by that, what I mean, I'm sure most everybody here understands, that the ACA had a change in the match rate, or as the federal portion goes down, the state portion goes up, currently operating under where the state matches a portion of it at 6%, that increases to 7, soon to increase, then, to 10. That, along with some other ACA requirements, basically consumes all of my increased funding.

For those of you who may have heard some of the comments I made yesterday at Health and Welfare with regards to PBM's, with regards to some requested pharmacy changes or at least some proposed legislation there, that comes with a cost. I don't have the funds at this point.

Jay, for lack of a better word, duly noted. And if funds become available, that would be on the list, but that's just a reality of where we are today.

And on that, I'm happy to entertain question on that and then we we'll go into just kind of a general report.

MR. TRUMBO: We certainly understand and appreciate the budget implications. And I think kind of the approach that we were looking was maybe not necessarily to try to add dollars to the budget as much as try to come up with strategies that could deal with what's causing those expenditures to escalate particularly so dramatically.

COMMISSIONER MILLER: I'd be more than happy to explore that for a number of different reasons, what impact it has on your day-to-day operations, as well as some of the risk

management that may take place there, but if that is some of the issue, just to help as it relates to the quality of care and what's taking place there. So, I see that as a win/win. So, absolutely, if I can help spur that along, I'd like to do so.

MR. TRUMBO: Okay. We appreciate it.

COMMISSIONER MILLER: Okay. Any other questions on that?

CHAIR PARTIN: No? Okay. Do you want to just go into the rest of the report?

COMMISSIONER MILLER: I'll go right into the update. In fact, I think Kristi Putnam will be joining me as well.

CHAIR PARTIN: Okay. So, we have questions left over from the last meeting under the My Rewards Program. One question was about is glaucoma screening covered under Medicaid or is it part of the My Rewards Program?

COMMISSIONER MILLER: What I'd like to do real quick, and one of the things we're going to talk about will be on the 1115 and that kind of goes hand-in-hand with that, was just to kind of do some general comments first, and part of that would be what I'll just call some housekeeping items.

Behind me this afternoon, I have all of the Medicaid Directors. All of the Directors within my Department are here. That doesn't always happen. We plan on doing that in the future. I'm not going to call them by name or ask them to stand up but just know that we take this seriously and that all the Directors from Medicaid are here.

In addition to that, I also have with me both of my Deputy Commissioners, Jill Hunter, as well as my new Deputy Commissioner, Anne-Tyler Morgan. Anne-Tyler has been on board now just about a month and we have a quick base and a lot going on. She has been a good addition and she is replacing Veronica Cecil who has gone to do something different. So, I just want to acknowledge my team is here. In fact, my entire team is here today.

As it relates to the 1115, Mr. Carle, somewhere, give or take, about nine months ago, we were talking about when approval and whether or not the end of June, whether or not by the end of the second quarter, and here we are some eight months after that.

What I'm happy to say is that as I'm sure everybody here knows, two weeks ago

tomorrow, CMS approved our 1115. That was after a process that from date of filing some sixteen months. I believe I have said here before that many of my peers had said that a waiver request so elaborate as this one has been and some many changes could easily take up to eighteen months.

Yesterday, here in Frankfort, we had the Deputy Secretary of Health and Human Services at the federal level. Deputy Secretary Eric Hargan was here and they were taking some satisfaction the fact that as a group, although it seemed long to us, but as an Administration, it was basically done within one year, so, from the time that new Administration had come on board, which I think that is a significant point; that part of our sixteen-month time frame was also the lapse over the transition of not only a change in Administration but a change in parties as well. So, that added to that.

Kristi will touch on some of the operational sides and some of the questions that you have; but as part of that, I would be remiss if I did not comment on from the standpoint of litigation that has been filed and at least what we see as being the impact of that in what I will call the short run.

And in the short run, the

immediate impact, I would say, is nothing. We continue to go forward with exactly where we had been in implementation to gear up to be in place on the alternative benefit plan, the major changes there on 7/1 of '18.

There's no doubt in my mind. In fact, litigation was not surprising to any of us. For those of us who are staying close to it, some of us had said I thought the time frame for that litigation to be filed may be measured in hours and not days, and, in fact, it almost took two weeks. So, we fully expected it.

And in many ways, that added to the time frame of the approval of the 1115, being that we were going down a road that was distinctively different than had been approved before, that one needed to make sure, as they have said, that the i's were dotted, the t's were crossed and everybody felt comfortable that CMS had that authority to grant such a waiver.

The Department of Justice signed off on it. That in itself was not a quick process, and that's what was taking so long and couldn't necessarily say that at the time, but we knew that review process in preparation because of

what everyone anticipated.

Obviously, as stated yesterday by again Deputy Secretary Hargan, that we believe, the federal government believes that we are in a very defensible position as to that they have the authority to grant us to do exactly what we had requested to do under the waiver.

I might add for those of you who kind of keep up with the details or get into the weeds of it that no one from the State of Kentucky was named in that litigation. It's strictly at the federal level and questioning whether or not the authority to do what they have granted us, allowing us to do, whether or not that is within their purview.

And there's not a doubt in my mind, no natter who prevails at what court level, it will eventually be a Supreme Court decision. I think by the nature of what it is and the impact that it has and the attention that it has, it will go to that level.

In the meantime, with the way we are operating today, it's business as usual and trying to get all the things we need to get done as it relates to the implementation of the 1115, and

those have already started, which Kristi, the Project Manager who has sat at this table numerous times in the past, will kind of walk you through and then we'll just field questions.

MS. PUTNAM: Good afternoon. Thank you all for the opportunity to come again and help some questions and provide some additional details.

Dr. Partin, would you like me to go ahead and answer first the remaining questions?

CHAIR PARTIN: Yes.

MS. PUTNAM: The questions pertaining to the My Rewards Program, I'll take each one individually. The first one, is glaucoma screening covered under Medicaid or is it part of My Rewards Program?

For individuals who don't have a medical condition that would indicate that as part of their health care, their ongoing health care, it would be part of the comprehensive vision screening. So, that would be part of the My Rewards Program.

If there was a medical condition that would negate it being part of the preventive services, then, it should fall under the health care instead, the medical portion of their

coverage, then, it would move over to the medical side.

CHAIR PARTIN: So, for instance, if a patient was complaining about a red eye or pain in their eye but they weren't diagnosed with glaucoma, the glaucoma screening would be paid for under regular Medicaid, not My Rewards because they had a symptom that screening was done for?

MS. PUTNAM: That would be medical, yes.

CHAIR PARTIN: Not specifically an injury, just a symptom, you know, their eye was red or the eye was painful.

CHAIR PARTIN: I don't know the answer to that but I will get clarification. I'm looking back. It goes to medical. Okay. That was my understanding is medical. It goes to medical. That would be covered under medical.

DR. GUPTA: So, in general, there are no symptoms for glaucoma and that's why the screening is so important because, in most cases of glaucoma, it's totally asymptomatic. It would only be symptomatic if it was very far advanced.

So, that's why I think the screening is important, especially if you're

African-American, you're over the age of 50 and you have a family history.

MS. PUTNAM: We agree that the screening is important. As it currently is now, the vision benefits, preventive vision has not been highly utilized.

And, so, as part of it, I think we've talked about it with you all before, as part of the My Rewards Program, part of what we intend to do is incentivize getting those preventive screenings.

And, so, what we want to do is really work with our Managed Care Organizations, our partner agencies, our assisters, our FQHC's to make sure that we are highlighting the importance of getting those preventive screenings.

And we talked a little bit before about the fact that, yes, it costs My Rewards' dollars to get those preventive services but they also get paid back into the account. So, it ends up being close to a wash for that individual.

DR. GUPTA: Thank you.

MS. PUTNAM: If there aren't any other questions, I will go into the second one.

Custom orthotics. The question is are those covered under My Rewards? And the

answer to that is that, no, they would continue to be covered under medical services, general medical coverage, and that's as described in 907 KAR 1:479(2). So, they would not be covered under My Rewards. It would continue under the medical.

Anybody have any questions on that?

The third question was around can there be a take back to providers? In other words, if there is a charge that's made and later the person is found to be not eligible somehow, will there be a take back of that reimbursement to the provider?

And the answer to that is that that's not a policy change from today. Currently, if we have a claim that's paid that was not Medicaid appropriate, the payment does have to go back; but what we are doing with the new system, for the My Rewards system is there will be some additional safeguards in place for providers that include an eligibility screen that shows the active My Rewards' status plus the balance of that individual.

And, so, what we are working on for some provider training is the ability to check that individual's active My Rewards' status plus

their balance of their My Rewards' account when they make the appointment and place that reserve, that hold on those dollars.

And, then, the provider will also have the ability when that person goes in for service, on the date of service to pull the information up again and just verify that they are active. If they are in active My Rewards' status at the time of service, that payment will go through as a claim, a valid claim.

CHAIR PARTIN: Sometimes people have a day off and they make all their appointments on the same day. So, they might go to the dentist in the morning and the eye doctor in the afternoon. Is the My Rewards' account going to be that up to date?

MS. PUTNAM: It will be. There is a responsibility on the provider's side to make the reservation of dollars, to put that hold on the dollars.

As long as a hold has been placed on that account, so, if they go to the dentist and it's $100, they go to the eye doctor and it's $200, both of those providers make their holds on the account, that money is held for thirty days. And, so, the person goes in for that appointment and these

providers are able to submit the claim.

CHAIR PARTIN: So, when does the provider put the hold on the account?

MS. PUTNAM: At the time that the appointment is made.

CHAIR PARTIN: Not when the patient shows up at the time when the appointment is made.

MS. PUTNAM: Right. When they make the appointment, the provider will have the ability to put a hold on those dollars. And, then, when the person comes in for that appointment or the day before - I know a lot of providers do check eligibility a day or two before someone comes in to the office - they can check back into the My Rewards' system, ensure that the hold is there.

There's also the ability, if the appointment is more than thirty days out, there will be the ability to extend that hold, so, go in at the twenty-nine-day mark and extend that hold for an additional thirty days.

CHAIR PARTIN: So, you would have to go back in and do it again?

MS. PUTNAM: You would. We would like to change that so that it's a longer hold,

but right now it's a thirty-day period.

MS. ALDRIDGE: Sometimes we check the eligibility for the day that they're there and we bill it; but, then, for some reason, months down the road or even a year, it comes back that they weren't eligible. We've had situations where we even print out that screen, the Medicaid screen showing they were eligible but, then, the money is recouped because they weren't. So, how is that not going to change with the Rewards Program?

MS. PUTNAM: I can't promise you that there will never be the situations where the eligibility shifts like you just described for the general eligibility, but for the My Rewards Program, they will either show up as active or not active.

And if they're not active, there's not a period in the future where they can be determined not active and it will impact that claim from the past.

MS. ALDRIDGE: So, it's totally separate than Medicaid coverage?

MS. PUTNAM: It's separate but it's in the same screen. So, it will be in the same provider portal, the HealthNet screen.

MS. ALDRIDGE: But my asking is

like in months to come, it's still separate. If they become ineligible for that date and you recoup the money from me as the provider for Medicaid services, you won't recoup the Rewards' part that was used even though they weren't eligible. Months down the road, you all went back and checked, and for some reason, they weren't eligible even though at the time we checked, they were eligible. Do you see what I'm saying?

MS. PUTNAM: Right. That's not changing with this but what is changing is that My Rewards account. It will not appear active if that person is not eligible.

MS. CURRANS: But it will all be on the same screen, right?

MS. ALDRIDGE: I don't think she understands what I'm asking.

MS. CURRANS: So, if I'm checking eligibility, won't I always see them as active? If I check eligibility and they're eligible, I will see active rewards; but if I see not active rewards and eligibility, I might question that.

MS. PUTNAM: There are circumstances where someone could be eligible for Medicaid services but they may not have an active My

Rewards' account, and I'll give you an example.

If someone is determined to be medically frail and they have opted not to make a premium payment, they wouldn't be getting their vision and dental under that anyway but they would not have an active My Rewards' account.

MS. CURRANS: That makes sense. Thank you.

COMMISSIONER MILLER: Back to your question or concern. Clearly in the past, and we continue in the future, I know as it relates to the eligibility screen, the eligibility systems, but through Benefind, through the changes we're making here, we're trying to see that individuals don't fall through the cracks.

MS. ALDRIDGE: Okay.

COMMISSIONER MILLER: But clearly from a federal standpoint, no matter when that individual is deemed not to have been eligible, we really don't have a choice. We have to qualify.

What we are kind of charged with and need to do is make sure that that eligibility system is as current as possible at the time when the service is rendered.

DR. RILEY: My question is if

the patient is eligible under Medicaid and has no funds in their My Rewards and they receive treatment, is that an out-of-pocket expense and do we have to have them sign something?

MS. PUTNAM: It would be an out-of-pocket expense. There are other options.

We've had some discussion with some providers about some of our FQHC's would like to provide opportunity to do some of the online learning right there in their offices because the credit for those is immediate; but that would be if they don't have a balance in their account, it would be an out-of-pocket expense or it would be an arrangement that the provider makes with that individual.

There is the ability for the account to go negative. For example, and I think I've gone through this a little bit before, if somebody comes in and they are there for just their dental exam, their comprehensive dental exam----

DR. RILEY: It's usually going to be an emergency. It's usually going to be an emergency probably requiring an extraction.

MS. PUTNAM: Right. And if that is a zero balance, then, that is a patient

out-of-pocket expense, but we are working very hard to make sure that we have information out there for people to go ahead and start earning My Rewards.

As a matter of fact, the ability for the My Rewards' accounts to accrue dollars started on January 1st. After we got the approval January 12th, we'll be looking back to January 1st to credit the accounts for the preventive services people get during the period of January 1st through July 1st.

DR. RILEY: And the second question would be Kentucky is a state that has noncovered procedures' legislation. So, if the insurance isn't covering it, we are allowed to charge our regular fee.

So, is the fee to that patient going to be the office fee or the Medicaid fee because it's noncovered?

MS. PUTNAM: It is still considered to be covered as part of the My Rewards Program. So, that does fall under the fee-for-service fee.

DR. RILEY: But you're not paying anything for it.

COMMISSIONER MILLER: If it's a

noncovered service, it's never been covered under Medicaid, we'll clarify that, but that would be at the normal fee; but if it has been a covered service and is covered under My Rewards, it would be at the Medicaid fee-for-service rate.

DR. RILEY: Even though My Rewards is not paying for it.

MS. PUTNAM: It's still considered to be covered because it's reimbursable under Medicaid if it's covered under the My Rewards' services.

DR. RILEY: Okay.

CHAIR PARTIN: I'd like to go back to the My Rewards' account where the provider can look to see what's available.

The things that are covered under My Rewards, those are mostly screening things and patients make appointments for those things way ahead of time, like six months so they don't forget that they need to go get their teeth cleaned or whatever.

So, that means that the provider has to go in every single month and remember that that person has an appointment every month because you don't see that on your appointment

screen. You don't know that somebody two months ago made an appointment for six months. You don't know that until--you only know that on the day they make the appointment and then the day that they're supposed to show up.

So, I guess I'm saying that that's going to be difficult to do.

MS. PUTNAM: That is something that we're looking at as part of the system is how far out can we have the reservation go; but at the moment, it's at thirty days with the extension being needed, but we are looking at whether that could be changed.

CHAIR PARTIN: Can you do it on the day of the appointment?

MS. PUTNAM: To review the reservation?

CHAIR PARTIN: Yes, you can. You can do it anytime within that thirty-day window of the appointment.

MS. PUTNAM: And if you do it that day, for instance, they're seeing the dentist in the morning and the eye doctor in the afternoon, the dentist that morning reserves those funds. Does the eye doctor in the afternoon know that those funds

were reserved that morning?

MS. PUTNAM: Yes. As soon as the eye doctor looks up the account, they will be able to see the hold on the funds.

COMMISSIONER MILLER: Whoever is the second one cuing up would be able to see that.

MS. PUTNAM: Yes.

CHAIR PARTIN: Okay.

DR. COMPTON: For clarification, just to make sure that I'm right and we're all right, this is all just the expansion population, the My Rewards.

MS. PUTNAM: For the My Rewards for vision and dental, it is the expansion population, yes, for using that for their preventive vision and dental.

DR. COMPTON: And everything else stays just like it's been.

MS. PUTNAM: Our medically frail, our pregnant women, our children, our adult caregivers, they all still receive their vision and dental as part of their Medicaid services.

MS. STEWART: I have a question about the My Rewards. You reserve the dollars for thirty days. How quick do you have to send your

claim in to collect those dollars because if you're, say, thirty-five days out, your hold comes off, you've not processed the claim yet? So, do you have to follow up until the claim is paid to make sure that monies are still on hold from that account?

MS. PUTNAM: Once you submit the claim, so, if you submitted the claim within that thirty-day period, those dollars are reserved. The claim gets paid against that hold.

If you are submitting the claim, let's say, on day twenty-nine and you see that your hold is about to expire, you can extend that hold for an additional thirty days to ensure that the claim gets there and you are paid against that hold.

MS. STEWART: Again, it's something else we have to monitor.

MS. PUTNAM: Yes, and we're working on that and we have had some feedback like this on that and we're looking at ways to make that a little easier.

MS. STEWART: Okay. Thank you.

DR. ROBERTS: Is your estimated time of payment through the My Rewards - and I know it's speculation at this point - but do you expect it to be any longer or shorter than traditional payments

from----

COMMISSIONER MILLER: I would say we believe it's going to dovetail right in with the current fee-for-service.

MS. PUTNAM: If there aren't any additional question on the My Rewards, I can just kind of walk through the high-level time line and how we expect implementation to go from this point.

I think we've gone through it before with a PowerPoint with some information handed out, but just to go back to what we expect, we have, as of January 1st, as a pilot for Kentucky HEALTH community engagement, we have our SNAP employment and training.

Individuals are now not going to the DCBS offices. They are going to our local Workforce Board Career Centers to receive services for workforce support, education, training, whatever they need to do to qualify for their employment and training requirements.

That's a very small number of individuals. And, so, we are using that SNAP employment and training program as a pilot for our Kentucky HEALTH Medicaid community engagement services which will start in July.

The July community engagement will be phased in but I will touch on that in just a moment. Effective April 1st, that's our next milestone that we expect to have happen. April 1st is when the My Rewards' tracking system will be turned on.

And the look back for preventive services to January 1st, that will be the first look back that will be done in the system, the Medicaid Managed Information System, to credit accounts for people who have obtained those preventive services and that will happen April 1st.

Also on April 1st, the My Rewards' tracking system will include the learning management system, and this will be the first set of courses people will be able to take on health learning, financial literacy, those kinds of things. There will be an initial offering of courses and, then, those will be expanded upon as we're able to add more courses to that online learning management system.

CHAIR PARTIN: That's April 1st as well?

MS. PUTNAM: April 1st, yes, ma'am. And, so, people will have both preventive

services and the online learning courses as ways to earn My Rewards into their accounts ahead of any benefits changing.

And, then, July 1st is the anticipated date for the benefits to change from those who it impacts who will change from the traditional state Medicaid plan to the Kentucky HEALTH Alternative Benefits Plan.

And that is also when the community engagement will begin to be phased in and it will be done, on a statewide basis, it will be rolled out phased in on a two Workforce area, per month basis starting in July.

And, then, again, that will be done in coordination with our local Workforce Boards, our DCBS offices, making sure that we're talking with all partners who are involved just to make sure that each of those areas is ready to roll out at that time.

CHAIR PARTIN: So, the whole state is not going to go at the same time?

MS. PUTNAM: Not at the same time, no. It will be two Workforce areas in July, two in August, September, October and the last two would be November.

The exception to community engagement would be the eight counties who are currently included in the Paths to Promise demonstration grant in Eastern Kentucky. So, those eight counties will have no changes to what is happening with community engagement. They will be exempt from that until December of 2019 when that grant is expected to be expired.

COMMISSIONER MILLER: And, again, that is a federal grant.

MS. PUTNAM: Yes, a different federal grant, different demonstration.

MS. STEWART: I have another question. Have you given any consideration instead of it being a program, being a card that would work like a flexible benefit card so that it would eliminate the need for submitting a claim? We would just accept their card?

MS. PUTNAM: We have. That was one of the options that we looked at and actually had talked with a third-party vendor to possibly run that, and the cost was so prohibitive that we did not want to go down that road. There would be an additional layer of administration and an additional layer of system interfaces. So, it became very

cost-prohibitive.

COMMISSIONER MILLER: Any other questions on the 1115?

MR. TRUMBO: The Governor, I believe, stated that Medicaid eligibles would need to work and that if that got overturned by the courts, they would discontinue the ACA expansion. Is that correct?

COMMISSIONER MILLER: The Governor has signed an Executive Order that has effectively said that through litigation, if the Court overturns any portion of our approved plan, that at that point, that we will then roll back Medicaid expansion; that it is, effectively, to maintain Medicaid expansion, our alternative to that is to have the 1115 in place; that if that alternative is taken away, the 1115, as it has been approved, if that is taken away, then, that Executive Order gives some of us the direction to undo the Medicaid expansion, roll it back.

MS. CURRANS: And, realistically, how long would it take you to roll back?

COMMISSIONER MILLER: There has been some discussion. We haven't looked at that

too hard yet as to what notice it would take as it relates to the benefit change but it's not an immediate rollback. It's not gone overnight at all.

MR. TRUMBO: And that was set up initially from an Executive Order, the expansion, the ACA?

COMMISSIONER MILLER: You saw me kind of hesitate there. There's no record of the Executive Order itself that we've been able to find, at least that I've been notified of.

Clearly, the Executive Order, even if it was in place or without it, it still goes through the process of State Plan Amendment and that process of doing that.

In fact, the Executive Order itself doesn't allow that to happen. It may give the authority to the Medicaid Commissioner to go do it but that really doesn't give the authority to do it. You have to go through the process with the federal government and State Plan Amendment to be approved.

MR. TRUMBO: Okay.

COMMISSIONER MILLER: So, the Executive Order as far as the roll-up was more symbolic, if, in fact, it was actually signed. And it may not be unusual that one can't necessarily find

that Executive Order, but it's a process.

MR. TRUMBO: Thanks.

MR. CARLE: With regards to the eligibility requirements, for the work requirements, have you given any thought, since that's going to be such a Herculean event, it's not going to be easy in any way, shape or form, have you given any thought to certifying certain individuals, let's say, in hospitals where a lot of those people will be presenting themselves so that they could help with the certification process where you would control that? You would be the one authorizing them to do so based on your requirements, but, yet, they could help in the process because, again, these people will be showing up in the emergency room, they will be showing up for outpatient tests and that might give you some assistance in being able to bring this.

Even though you have a phased process, it still might get you there faster.

MS. PUTNAM: When you say a certifying hospital personnel to help, can you help me understand a little bit more of what kind of assistance you're speaking of?

MR. CARLE: You just had mentioned that you're going to be putting some of

your people through training so that when these people go to present for their work requirements, they're going to have to certify that these individuals have the appropriate eighty hours.

What I'm suggesting, whether it be hospitals or other facilities located throughout the state, that you, DMS, have a certification process where you could certify somebody in these facilities to help you with that.

We do a lot of that with companies like Amedisys and whatnot to get people on Medicaid. I'm just suggesting an assistance to what you're trying to do because you're looking at a population of well over 400,000. And even with the phased approach, you're not going to be able to keep up with this.

MS. PUTNAM: I think I can answer what you're getting at. When somebody shows up to a provider, be it at a hospital or another provider, that provider does not have the responsibility of knowing whether or not the person has completed work requirements.

MR. CARLE: Correct.

MS. PUTNAM: Is that what you're speaking of?

MR. CARLE: No. I'm suggesting an approach to help DMS to verify that these individuals have the qualifications to get into the program where they have the eighty hours per month; that you control a certification program for other individuals located throughout the state, whether they be in hospitals or whether they be in other nonprofit agencies that can help you with this process of approving their ability to be in Medicaid because they've met the eighty hours per month.

MS. PUTNAM: We certainly will not turn down help wherever it comes from. And along those lines, we have met with the Family Resource Youth Service Center Coordinators through the public schools who have computers.

And, so, the verification process is online and some people may need some assistance with that. So, we're certainly not opposed to looking at if there's a way for providers to help us do some of that.

CHAIR PARTIN: I have a question about medically frail. I was reading some information about a presentation - I'm sure where it was given - but, anyway, it was talking about using claims data to determine whether somebody was

medically frail.

And I'm thinking about some of my patients who are mentally challenged. They live on their own; but when they come to see me, their diagnosis isn't that they're mentally challenged. Their diagnosis is that they have hypertension or diabetes or whatever which wouldn't make them necessarily medically frail but they are. They're not able to work, even though they're living in the community and they're not receiving any kind of waiver services.

So, what do we do about those people? There was something that said that the provider could submit information but I don't know how that would happen.

MS. PUTNAM: There will be an attestation process for providers for situations like you just described who believe that they have individuals under their care who would qualify as medically frail. And, so, it would be an attestation process that the provider would then submit to that MCO that would be able to deem someone medically frail regardless of what the diagnosis codes through the tools say.

COMMISSIONER MILLER: I think

that's important to say that that's a tool in looking at the claims algorithm. That is just one of the processes of screening but there's basically four steps, I think so.

MS. PUTNAM: I think so. I'm looking for Dr. Liu. Yes. Dr. Liu is telling me yes.

COMMISSIONER MILLER: But that is just one of the processes. Now, at this self-attestation, it's a physician or provider signing off as well.

CHAIR PARTIN: So, where do we get that form to attest?

DR. LIU: Sorry to barge in.

MS. PUTNAM: No, no. Happy to see you.

DR. LIU: There are five categories of conditions that constitute medical frailty - physical health conditions, behavioral health conditions, substance use disorder, homelessness and impaired activities of daily living.

In many of those instances, especially impaired activities of daily living, homelessness and behavioral health conditions, we're largely going to rely on the health care professional

submitting a structured form that is a clinical attestation because the claims don't give us a really good view into that.

Right now, all of our Managed Care Organizations have received a draft clinical attestation form. It's a roughly four-page document. It's got a lot of big margins and it comes with an appendix that identifies all of the diagnoses that would qualify.

And just to give a little more detail, let's say you're a new beneficiary to Medicaid. You're applying for benefits. We would have no administrative claims' data to use a software tool to evaluate whether you're medically frail.

The enrollment process has a few screener questions. Do you have a chronic health condition? Do you have impaired activities of daily living? That would be messaged to the Managed Care Organization. They would be tasked with connecting this person to a clinician who could help evaluate and submit the documentation.

So, right now, what we're looking very much forward to is our managed care partners who all have standing clinician advisory groups giving us input on the form.

A final comment is that the qualifying conditions were identified by virtue of a supporting consulting company called Wakely that does our actuarial analyses. They have a lot of medical underwriting expertise. They engaged clinicians as well.

Through this contract, they examined many years of our claims to look at how frequent these conditions are appearing, what utilization is associated with those conditions and, then, they drafted the form.

We've also built into their contract in the year after the waiver program starts, after Kentucky HEALTH is launched to refine the form. So, we have anticipated a need to adapt as we go forward.

CHAIR PARTIN: So, how do we get this form? How do providers get the form?

DR. LIU: Can we share with the MAC? So, if you wanted to communicate with the managed care entities, especially through their standing clinician advisory groups, they have it available to share with those advisors.

And I would imagine we could also just send it directly to the MAC as well.

COMMISSIONER MILLER: Yes.

CHAIR PARTIN: So, the provider has to request it?

DR. LIU: It would be available through the MCO website, the DMS website. I'm sorry. I wasn't understanding. I thought you said right now if you individually wanted to look at the draft. That's what I was hearing you to request.

CHAIR PARTIN: No. I was thinking about my patients and how I'm going to do this for them and how I'm going to get this form to do it.

MS. PUTNAM: We'll make sure it's available in multiple places.

MS. CURRANS: Once that form is completed, it will go back to the MCO and, then, there will be an acceptance of that document or a rejection of that document that would then declare that patient medically frail.

COMMISSIONER MILLER: With an appeal process as well.

MS. CURRANS: Sure. It comes with all the other bells and whistles.

CHAIR PARTIN: And if they are medically frail, then, they are not required to pay a

premium and they're not required to pay copays. Is that correct?

MS. PUTNAM: Correct.

CHAIR PARTIN: And they're not part of the My Rewards Program.

MS. PUTNAM: Unless they choose to pay a premium to have access to the fitness activities and down the road sometime OTC, over the counter, yes.

COMMISSIONER MILLER: Additional questions on 1115 or any other particular items? I had planned on sitting here and going through two items, quickly touching on budget as well as 1115. Thank you.

MR. SCHULT: Actually, I'm sorry, I do have a question. I do have two simple questions and this is as a newer member of the Board, and I apologize if these are overly simple. They're not related to the 1115 Waiver. They're just more general questions and they're unrelated to each other.

My first question relates to Medicaid approval notifications. This is a simple printing question. My understanding is that when someone gets approved for Medicaid, there's multiple

notifications that might be mailed in a single day. Is that intentional or is that some sort of glitch?

COMMISSIONER MILLER: My reaction is that's a glitch but give us examples of that, and not here today but if you're aware of that, send us examples. If there's something we have going on within the system that that is taking place, we need to fix it.

MR. SCHULT: Okay.

COMMISSIONER MILLER: We've had issues like that in the past and I'm also not naive to know we'll continue to have different issues, but we had, especially when our current eligibility system came up and running, we had a number of issues - we all lived through it - but as far as those type of things taking place, I'm not aware of that.

MR. SCHULT: Okay. I'll get some specific examples to you.

And, then, the second question, like I say, unrelated to that, I have a question about copays when it comes to urgent care versus emergency rooms. And perhaps I misunderstand it.

My understanding, though, is that a Medicaid recipient has no copays at the ER but they do if they go to an urgent care type location.

Maybe I'm mistaken there, and perhaps this is a better question for the MCOs, but if everyone's intent is to have individuals utilize the emergency room less, then, is there a reason for that arrangement?

COMMISSIONER MILLER: I'll answer that two different ways or with two different facts, I guess.

In the past, the MCOs as our partners had the ability to charge copays with different dollar amounts, all of them relatively small based on different lines and types of services.

The decision had been made not to do that as much as anything, I believe, from a marketing standpoint - they may disagree with that - but from a marketing standpoint, and that's been in place now I'll say a couple of years. It's been a while.

Now, as part of our 1115 and going forward, much for the exact reason you just said, in trying to create some disincentives and trying to change some individual practice habits and would require the MCOs to reinstitute those copays for the applicable populations, that's going forward, but today those copays have been I say waived. The

decision has been made, a business decision on their part not to collect. Helpful?

MR. SCHULT: Right. So, the solution is institute copays back in the emergency room so that individuals don't have a preference on which one they go to?

COMMISSIONER MILLER: Exactly.

MR. SCHULT: Okay. Thanks.

COMMISSIONER MILLER: Thank you.

CHAIR PARTIN: Thank you. So, we've got a little bit under an hour and we've got all the TAC reports. So, I'd just like to ask you all giving your reports to keep that in mind so that we can adjourn on time.

First up is Behavioral Health.

DR. SCHUSTER: I'm so glad I'm at the front of the line this month. I've already crossed out a bunch of my report.

Good afternoon. I'm Sheila Schuster. I'm the Acting Chair of the Behavioral Health TAC. We had our meeting on January 9th and five of our six TAC members were there, so, we had a quorum. We had five Medicaid MCOs, DMS and the Behavioral Health Department, as well as lots of

people from the behavioral health community.

The provider letter regarding the IMD expansion was distributed and discussed, and we would like to thank Medicaid for implementing the CMS policy. We think that opening up additional inpatient treatment opportunities for acute psychiatric episodes is going to be very good for consumers.

At the time of the TAC meeting, the 1115 Waiver had not yet been approved. And, so, we had a discussion, as we have had for the past sixteen months, about what medically frail means. Since then, it's been approved and we will be inviting Dr. Liu to again come to meet with us to discuss the medically frail determination.

I would ask you, Dr. Liu, if the Behavioral Health TAC could get a copy of what's being looked at in the attestation form?

DR. LIU: Yes, ma'am.

DR. SCHUSTER: That would be wonderful. Thank you very much.

We continue to be concerned about access to the right medication and the right dosage at the right time because that's the one thing that keeps people with significant behavioral health

problems out of the ER and out of the hospital and out of homelessness and so forth.

We had not received a response from DMS to the recommendation we made in November. So, we will put on the record again this recommendation, that all MCOs have the same formulary to match that of DMS and to use the DMS pharmacy and therapeutics' process to make changes in the formulary.

And we recommend that these changes be reflected in the RFP being developed to be issued to the Managed Care Organizations bidding on being MCOs in Kentucky.

We also make this recommendation, and that is that the Medicaid Pharmacy and Therapeutics Committee meeting on the recommendations of the PBM, that those recommendations be made available to the attendees at the time of the meeting.

At the last meeting, I understand that they were not available. And, so, there was discussion and votes but the people in the audience didn't know what was being recommended which makes it very hard to be an informed observer of the process or even to sign up to speak and that those be

posted on the DMS website within seventy-two hours of the P&T meeting.

We also spent a large part of our time talking again about the problems of youth remaining in psychiatric hospital settings for a long time because there's no appropriate stepdown programs.

And, so, our recommendation is that all parties currently engaged in that discussion both within the Cabinet and outside of the Cabinet renew their efforts to find solutions for these youth. It's not good for the kids. It's not good for the hospitals. It's not good for families.

If there are additional resources or expertise that are in the Behavioral Health TAC or in our community, we are eager to be of assistance in this process.

And, finally, we had a discussion about telehealth, and our recommendation is that any regulation concerning telehealth be inclusive of the full array of behavioral health providers and services.

I would also like to note that two bills currently being looked at in the Legislature, Senate Bill 7 and I don't have the other

bill number, would remove the Consumer Rights and Client Needs TAC.

And I know that TAC has not met for some time and maybe that's why the Cabinet is recommending that, but it seems to me there's never been a more urgent time for us to have a TAC that looks at consumer rights and client needs.

So, I would hope that the MAC would go on record as saying they want to keep that TAC or something, communicate with legislators. Senator Julie Raque Adams and Senator Alice Forgy Kerr have that, and I'm assuming that it came from the Cabinet, but I do think we need to keep that TAC.

CHAIR PARTIN: You're making that as one of your recommendations?

DR. SCHUSTER: I'm making that as a recommendation on the spot. Thank you, Madam Chair.

CHAIR PARTIN: Thank you.

DR. SCHUSTER: Was that quick enough? Sharley is not happy.

CHAIR PARTIN: Dr. Liu, would you also send the draft of the attestation form to the MAC as well, please?

DR. LIU: Yes, ma'am. I was

just speaking with Cindy Arflack. We have a meeting next Wednesday about the communication strategy with the Managed Care Organizations. So, it's a big effort.

I did also want to mention there are plans in April to have wide forums in all eight of the Medicaid regions.

So, I will get that out to you as soon as possible. I don't want to get ahead of Katherine Easley who is coordinating this communication strategy but I'm eager to share it with you, and I'll do it as early as I can.

CHAIR PARTIN: Thank you. Children's Health. Consumer Rights and Clients Needs. Dental.

DR. RILEY: We did not meet.

CHAIR PARTIN: Nursing home.

MR. TRUMBO: The Nursing Home TAC is looking to fill three open positions. That's our report.

CHAIR PARTIN: Home Health.

MS. STEWART: We have not met. We meet in February.

CHAIR PARTIN: Hospital.

MR. CARLE: The Hospital TAC

met on November 1st. We've reviewed that information here and appreciate the response that we got from Commissioner Miller and his staff and just wanted to recognize as such.

CHAIR PARTIN: Thank you. Intellectual and Developmental Disabilities. Nursing TAC. The Nursing TAC did not meet. Optometry.

DR. COMPTON: We did not meet. We meet again on February 22nd.

CHAIR PARTIN: Pharmacy. My goodness. Physician Services.

DR. GUPTA: Our TAC meeting was unfortunately rescheduled to tomorrow because of weather.

CHAIR PARTIN: Thank you. Podiatry.

DR. ROBERTS: Awaiting modern formulation of the Podiatry TAC.

CHAIR PARTIN: Primary Care.

MR. BOLT: David Bolt representing Chris Keyser, the Chair of the Primary Care TAC. We did meet at our regularly scheduled time two weeks before you all meet.

We actually took a measure of time to actually not just make some recommendations

but to advance some positive reports of good things that have happened. We are coming back on the wrap payments and noting that while DMS is working toward a process for reconciliation back to July of 2014, that the TAC asks that DMS give this a priority. It is becoming a major issue financially with some of the clinics.

And the TAC and its membership are willing to assist DMS is designing a workable and routine process for that going forward.

Uniform risk scoring. I guess, Commissioner Miller, I kind of got my hand slapped on that. You all sent a note back saying we needed to make a suggestion.

And what we're going to offer is that we regard this as a contractual requirement, but I think provider groups would be very open to assisting DMS in this effort to define and develop a consistent process that would be of benefit to the MCOs, the providers and DMS itself.

The updating of provider enrollment information from the OIG is becoming an issue, and the TAC recommends and is willing to provide assistance in development and implementation of a process to expedite the updating of provider

information between OIG and DMS.

I would note that our group has been working with the provider portal now for about a year, and I'll have to tell you, it's all but flawless. I can't wait until March when you all bring it up. I think that providers will see a dramatic improvement there.

Credentialing and loading, and this is a recommendation, the TAC renews its request to prioritize the timely loading of PCPs by all MCOs. We regard this as a contractual manner to be monitored and enforced by DMS.

We find it concerning that the provider group, primary care providers who are held responsible for improving quality and controlling the cost of care cannot be considered a priority group for loading to a par line by either DMS or the MCOs.

On a positive note, the auto-posting system that we've harped and complained about for over two years is beginning to work and we're very, very happy with that. We are seeing a good bit of success with two MCOs straight up and the others assure us they are working on it.

Licensure regulations that we raised in the TAC four months ago, I'm happy to

report that those two licensure regulations are moving through the process and I believe up for review toward the end of this month.

The modifier, we're very appreciative of DMS and its efforts to resolve this problem. It would be a modifier for non-face-to-face encounters paid on a fee-for-service basis.

We are working with DMS, with the MCOs and with a small group of clinics to test it to make sure that it works before we move it out to the general population.

And, finally, we're pleased to be involved in the project on quality improvement measure development and commend DMS for the focus on improving the health of Kentucky's Medicaid members.

CHAIR PARTIN: Thank you. Any questions?

Therapy Services. Okay.

MR. SCHULT: To touch on what Dr. Schuster said, I do sit in a consumer advocacy seat and I don't know what I'm committing to here, but I would be happy to help revive and/or lead the Consumer Rights and Client Needs TAC.

Like I said, I don't really know what that entails, but I'm happy to do it. And

if anybody else who is on a consumer advocacy seat, if you'd like to please, please join me, it would be greatly appreciated.

DR. SCHUSTER: We'll elect you Chair immediately and you can appoint a Vice-Chair.

CHAIR PARTIN: Anything else? Any other business?

MS. STEWART: I have one more question. How long will it take to get a clean copy of our revised bylaws?

CHAIR PARTIN: Sharley?

MS. HUGHES: I'm sorry. I thought you were going to make those changes. I can have them sometime next week.

MS. STEWART: Thank you.

MR. BOLT: You may want to push those out to the TACs also.

MS. STEWART: That's what I was wanting to know so I could take it to our TAC.

CHAIR PARTIN: Yes. I think that would be important for the TACs to have that.

DR. GUPTA: I did have one other question. At the last meeting, the Dental TAC, I believe, had made a recommendation about making a change to the EBT program or Food Stamp program and I

saw that I think DMS had responded that it's not in your jurisdiction to make those changes.

I was wondering who could we approach to make such changes to the EBT program?

COMMISSIONER MILLER: That be a federal but we'll have a discussion on that.

CHAIR PARTIN: Anything else? Thank you, everyone, for attending. We need a motion to adjourn.

MR. TRUMBO: So moved.

DR. SPIVEY: Second.

MEETING ADJOURNED