CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

March 22, 2018
10:00 A.M.
Room 171
Capitol Annex
Frankfort, Kentucky

MEETING

APPEARANCES

Elizabeth Partin
CHAIR

Chris Carle
Julie Spivey
Steven Compton
Gary Marsh
Melody Stafford
Jay Trumbo
William Schult
Teresa Aldridge
Jerry Roberts
Susan Stewart
Peggy Roark
COUNCIL MEMBERS PRESENT

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AGENDA

DR. PARTIN: Since we are in such a big room, I would like to remind everybody to turn your microphones on when you speak. You can turn them off when you're not speaking so that our reporter can hear everything.

The first item is approval of the minutes from our January meeting.

MS. ALDRIDGE: Dr. Partin, we didn't get a copy of them, an email or anything on those. I didn't get the last ones either.

DR. PARTIN: Did we not?

MS. ALDRIDGE: I haven't.

DR. PARTIN: Okay. Did everybody else? No? I don't remember. Okay. Well, we'll table that for a minute.

We didn't have any items on Old Business unless somebody has something that they would like to bring up.

Okay. Then, let's move along to updates from Commissioner Miller.

COMMISSIONER MILLER: Good morning, ladies and gentlemen. Steve Miller, Medicaid Commissioner.

MS. HUNTER: Jill Hunter, Deputy Commissioner for Medicaid.

MS. PUTNAM: Kristi Putnam, Program Manager for Kentucky HEALTH.

COMMISSIONER MILLER: We plan on going over a couple of different things today. In fact, after I do a quick update, then, Jill will touch on the 1915(c)'s and, then, Kristi will go over the 1115 as well which was one of the purposes of today's meeting.

What I wanted to touch on real quick from the standpoint of obviously we're in the middle or towards the end of a legislative session. A lot has been said about the different bills that are now currently still in process. I just kind of wanted to touch on a couple of those and how they somewhat impact Medicaid.

Of course, one of the ones that we have spent a lot of time on and has gotten a lot of play, a lot of visibility is SB 5 dealing with the pharmacies and PBM's and we're in the process right now of going through that bill.

It seems to have gone from what I will call a carve-out which candidly would have created a lot of different issues for Medicaid to becoming a transparency bill to be able to gather more information to help us make better decisions

going forward.

There is a second part of that bill which or at least in that process as it relates to maybe some change in the dispensing fee which would be part of the budget process itself.

In addition to SB 5, SB 53 which many refer to that as basically the bill to limit the number of MCOs. It initially started off to limit the number to two and now has been amended to limit the number of MCOs in the state to three.

But more concerning than that to me and to the Department is the process that it would bring about as far as what I will call the leveling of reimbursement between urban and rural providers. It basically set out a formula where the rural providers would be paid the median of the closest urban area.

The logistics of that is real, real difficult. The fiscal impact of that has a potential of being huge to the state. As an example, one component of that, Mr. Marsh, was from the standpoint of what it did on long-term care. As you know, there's urban/rural; and as we read through that, it would move all of the rural providers to the urban rate.

MR. MARSH: I guess that would make all the rural providers pretty happy, wouldn't it?

COMMISSIONER MILLER: I think it probably would. Well, depending whether or not it was going to be budget neutral, so, depending on what was done there.

MR. MARSH: So, let me stop you just for a second because you asked me a question. So, I get to ask you one.

COMMISSIONER MILLER: That's fair.

MR. MARSH: What is the rationale behind the median urban rate for that calculation?

COMMISSIONER MILLER: I don't necessarily mean to speak for Senator Meredith who introduced the bill, but his concern has been that rural providers are at a disadvantage as compared to urban and that that was his way of trying to level the playing field.

MR. MARSH: Generally that is true, but it's not a one-for-one type of comparison, but there is some carryover between urban and rural, especially what's considered to be a rural provider

is relatively close in a county to an urban center.

COMMISSIONER MILLER: From where I come, we refer to that as kind of a cliff instead of a phase-out. It's like a hard-line arrangement. So, point well-taken.

We calculated an estimate just on the nursing facilities and that would be about a $75 million additional expenditure state and fed, state being somewhere in the neighborhood of around $22 million of that number.

An additional bill, HB 69, what we just refer to as the credentialing bill, and that is to effectively establish a uniform credentialing process among all five MCOs being overseen by the Department.

That concept is one that we have tried to nudge for a period of time and it looks like now we will, we being the Department, will be responsible for going out and contracting with a certified credentialing organization, CCO - another acronym - but effectively to try to get all five MCOs or whatever that number of MCOs is going forward all using the same credentialing process. I think that's a step in the right direction.

SB 112, referred to as the

telehealth bill, it basically starts bringing us up to what I call current times as it relates to establishing payment for services for providers within their scope of service. It's basically trying to expand the availability of telehealth but also to kind of set a structure as to how that reimbursement will work. It waits to be set in regulation.

In addition to that, obviously the budget bill. I don't think it's an understatement to say that there is a lot of mashing of teeth over that right now.

As usual, there are three different proposals being the Governor's recommended budget, the House and the Senate.

From a Medicaid point-of-view, all three are very similar, some fine-tuning around the edges, but all three are essentially the same. Under all three, Medicaid is subject to the six-and-a-quarter reduction, six-and-a-quarter percent reduction, as are most Departments across the state.

That makes the Medicaid budget extremely tight and one thing I would kind of like to drive home with that and kind of keep it at a high level; but when one looks within the Medicaid budget and sees an increase in funding of approximately $250

million over the two years - it sounds like a lot of money and in most areas, it is - the Medicaid spend per day in state funds is just under $7 million a day currently.

The $250 million increase, the ACA requirement, the change in reimbursement rate, our funding rate, the FMAP rate from the federal government as it goes moves from five to ten percent eventually. That change alone for the next two-year budget cycle will cost the state an additional $230 million.

So, a $250 million increase goes away and gets consumed pretty quickly in that environment.

As part of that, I might add that also includes a 230 million--also includes the State beginning to pick up a big portion of the CHIP funding which previously had been 100% funded by the federal government. And starting 10/1 of '19, that rate, we the State now need to pick up a portion of it.

That's somewhat of a high level as it relates to some of the legislation that's in play. What I would like to do is at the next meeting, we'll come with more of a detail as to what

actually took place from a legislative standpoint and give you a little bit more details on the budget itself, but, again, all of that is in play and still subject to change until the Session ends.

I guess we'll just take questions at the end, even though I started off with a question and then got a couple, but I'll turn it over to Jill Hunter to talk about 1915(c)'s.

MS. HUNTER: Thank you, Commissioner. Good morning. I'd like to make two announcements before I go into my presentation. We've had two staffing changes, both for the positive.

I believe we've got one of the individuals here, so, I'll share hers first and, then, an individual who is back putting out fires so we could be here, so, he's not with us this morning.

Stephanie Bates is in a dual role now. Stephanie will now be the Director over the 1915(c) which is over in my side of the house. That's the waivers that we talk about, the Home- and Community-Based Waivers. She will be functioning as the Director in that shop working directly under me.

She will also continue to have a relationship with the managed care entity working

with the foster kids. So, there is a Foster Children's Project working directly with the Department for Community-Based Services. Stephanie will continue to manage that. So, she will hold a dual role going forward.

So, if you need anything from Stephanie, I'm sure many of you have worked with her in the past in her managed care role. Cindy Arflack will continue to carry that ball forward and do great things as she always has. Stephanie will move over and now be a Director.

Stephanie is here with us this morning; and if you need anything from her, she is a great person to work through.

I'd also like to make a second announcement. John Inman - he's not with us this morning. Again, he's over at the shop working on a project, unless he snuck in behind me and I don't know it. He is going to work in a dual role as well.

He will be serving under the Commissioner's Office as well. He's the Director of Program Integrity. He has a background in law. He is also a CPA. He is also a former police officer.

So, he has our Program Integrity shop and he will also be providing policy

and legal support, not legal guidance but legal support as an attorney to the Commissioner's Office.

So, if you need anything from John or Stephanie, I'm sure they will be great. I know they are great. As to the Commissioner's shop, we're excited to have them up there with us.

So, if you need anything from them, call our main line and Donna can get you to them, or if you have their direct number or if I can get you any numbers, I'll be glad to share them.

MR. MARSH: Will either of them have responsibility for the PPAC?

MS. HUNTER: That's mine and Stephanie----

MR. MARSH: You're going to keep it.

MS. HUNTER: I'm going to keep it.

MR. MARSH: Congratulations.

MS. HUNTER: Thank you. Thank you. Yeah, I don't think he's going to let me off the hook for PPAC, and Stephanie will continue to serve with me. She is my right arm and most of the brain on that. So, we'll continue to keep that role as well in my shop.

So, a little bit about what's going on in 1915(c) redesign, and this will be the first time I've sat in this chair and not begged for money. So, normally when I'm in this chair, I'm begging for money for my 1915(c).

So, I won't be doing that from you all because you're on my side. So, you're with me when I'm begging for money from the Legislature. I'm always trying to get more funding for the 1915(c)'s.

That's the most important thing we serve. If you think about it, that's what Medicaid was designed for. So, while every life is important, these are our most fragile citizens in the Commonwealth.

So, usually I'm in a begging role. So, let me change my role a little bit and tell you what's going on.

We are working through waiver redesign. I know you've probably heard that before. If you've spent some years working with Medicaid, you've heard us say waiver redesign before and waiver redesign historically in 1915 has made it all the way to the kickoff and then it stops.

So, we are going to take it and run forward to the best of our ability and continue

to manage the waiver redesign. We're very excited.

We have taken two things. We have looked at our own house. When you start a project this important, you better look at your own back door first. My mom always said keep your own back porch clean before you go clean anybody else's. So, we're definitely doing that.

We're taking a look at what does our shop look like and how could we better improve the way we manage our processes in the Division.

So, we will be addressing that, and we're also addressing what can we do to improve the way we administer waivers. When Commissioner Miller said to me, I want you to come back and I want you to have 1915(c)'s, I was a little gun shy because the next words out of his mouth was, that's a heck of a way to run a railroad. It's the most important thing we do but we really need to give them the support they deserve and maybe haven't had in the past.

So, I took it as a blessing to be able to come back and serve that group, and redesign is just another step in the right direction of continuing to serve them with the very best of our

abilities.

We have held four focus groups across the Commonwealth - we did this this fall - at ten different locations. We met with the recipients, their caregivers which are oftentimes family members and two levels of providers. We met with the leadership in the provider shops and we also met with the direct caregivers.

So, we had four separate focus groups at each of the ten locations, and the blessing with that was people could speak very candidly. No matter their role, they had a focus group designed just for people like them. So, it worked beautifully.

We saw, if I remember, we saw 488 separate individuals, many of them recipients. So, that was a first. That hadn't happened in the past that recipients had been brought to the table to talk with us and offer suggestions on improving our waivers. So, that's the first stop.

Continuing to move along, we have created a Project Governance Team and we are very privileged to have Secretary Brinkman in the Governor's Office who is the Acting Secretary in our Cabinet be a part of our Project Governance. It's

very exciting to have someone at that level supporting this project. He is passionate about it, to say the least. He rivals my passion in it. He gets very excited talking about it. He knows we're doing the right thing and we have his support, the Commissioner's support, Eric Clark, our Chief of Staff. We also have other individuals, the Commissioners in DCBS, DB/HID, Behavioral Health, as well as DAIL, Aging and Independent Living.

So, we're very excited to have a broad governance over this waiver redesign versus just keeping it in Medicaid. It's not the right answer to try to just keep it in that single silo. So, we've branched out and we're working across the agency for the good of these recipients.

We recently, actually Monday, we released the comments from the waiver redesign. The first focus groups, we released the comments. What were we hearing from folks?

Navigant traveled with us. They're our consultant in this adventure and they went through, of course, model procurement and were the successful bidder and they released with us a set of comments that we took from the first ten focus groups.

And what I can do if it's okay with Dr. Partin is release a copy of those to the MAC as well.

DR. PARTIN: Yes, please.

MS. HUNTER: Thank you, ma'am. You might have gotten them in other capacities if you're on one of our list serves in another capacity, but we'll make sure you all get it as well. I'm sure you will be pleased to know that there are good questions, things we're doing right and always opportunities for improvement.

So, going forward, we're going to have some town hall meetings. When we move into the spring - I know we're supposed to be in spring, but it's snowy, so, I refuse to admit that we're in spring - when we move into real spring and I see the sun more than an hour a day, we're going to have town hall meetings where we can have the individuals come back and talk with us.

And what we will be sharing at that time is what have we learned as we have gotten our own back porch clean, as we have cleaned our house, and as we've attempted to get the waivers more consistent?

We are sitting on five, six

different waivers and a single title. So, a single respite care or caregiver is defined five or six different ways between the waivers. That's chaos at best. How do I as a servant to a provider say, I need you to understand how to do one thing six different ways to manage your population when you're just trying to see patients every day? That certainly wasn't supportive.

So, we're trying to get some consistency in the waivers; and during the town halls, we'll be sharing what we've changed with the consistency, the recommendations we have for change and improvement, just language changes, improvements in the way we operationalize the waivers but not direct changes to the waivers at that time, just language cleanup and, then, what we've done in our house, and that will be shared in the town halls.

Those will be open to the public. They will be in May. We're going to schedule those in the evening local time, starting at about 5:00 p.m. local time.

We found that one of our chief concerns in the fall meetings was that they were during the day. And if you have a mom and a kiddo and the kiddo is the recipient, how can Mom or Dad

come to a meeting when they need care for that child during the day if it wasn't a school day or the child stayed home during the day? How was that the right answer and it certainly wasn't.

So, we're moving these to evening. So, we'll have these more amenable to people's schedules. So, again, open to the public, 5:00 p.m. local time. No RSVP.

Of course, we're the State. So, we're going to be in some of the most cost-efficient locations we can because we don't want to spend our money on locations. So, we're going to be in schools - they've been real kind to us - as well as colleges and local universities, and they will be open to the public and come on and see us if we're in your area.

We'll make sure you get that schedule so when we're in your area, if you'd like to come out and see us or see what we're doing and listen in, we'll be glad to have you.

Again, there will be ten locations - Prestonsburg, Somerset, Lexington, Frankfort, Florence, Ashland, Louisville, Bowling Green, Owensboro and Paducah. So, we always say we're Paducah to Pikeville. So, we're across the

Commonwealth with those locations. And we'll make sure, Dr. Partin, that you have the locations you can share with your team or we'll share, if it's approved on your behalf, with the team.

DR. PARTIN: Sure.

MS. HUNTER: We look forward to you all joining us. And if you have questions, I think the Commissioner said after Kristi speaks, questions at the end, but if you need me, you know where to find me.

MS. PUTNAM: Good morning. Part two of our updates is the 1115 and where we are with that. And I understood that you all had some specific questions around the public stakeholder meetings, as well as someone to provide some information about the provider forums that are planned as well and some of the questions that are being asked.

I first want to touch on the stakeholder forums. These are meetings that we're holding again in different locations across the Commonwealth so that we can provide information to the public.

You should have in your packet a presentation. This is the actual presentation that

we walked through during the very first stakeholder session that was held at the Transportation Cabinet on March 8th.

We do walk through an overview of what these forums are intended to cover, as well as an overview of Kentucky HEALTH itself and, then, we provide updates including what our outreach is, our outreach plan and calendar and what the actual outreach notices look like and, then, we talk about the upcoming milestones.

And the very first forum that we talk about the upcoming milestone is the My Rewards' kickoff on April 1st which includes both the technology change and the ability for beneficiaries to earn the My Rewards' health spending account virtual dollars.

We then took questions from the participants and we recorded those questions. And, so, the questions that were asked by the participants are actually also provided to you in your packet. It's stakeholder forum questions and these were rolled up.

So, we had a number of questions that were around the same type of question. You can see the types of questions being asked.

First and foremost, we had a number of questions around community engagement which we expected.

We also had some overall Kentucky HEALTH questions regarding coverages and different types between Kentucky HEALTH and Medicaid State Plan and eligibility groups and, then, we had a few questions about My Rewards, that being the first piece that's implementing on April 1st.

The presentation itself, I just wanted to call your attention to the schedule that's actually on page 3. We were in Frankfort for the very first meeting. We will then rotate out to a different location in the communities across the Commonwealth, but we do have a stakeholder forum planned for each month all the way through December of 2018, again, alternating between Frankfort and a location out in the Commonwealth.

So, if you take a look at the schedule on page 3 of this presentation from the stakeholder forum, you can see that schedule, and we'll be glad to provide you all, with Dr. Partin's permission, of course, with the details on those locations and when we will be in your area, and we would invite you all to come.

The stakeholder forums, they

were very well-attended. We had 75 individuals at our first one here in Frankfort. We do anticipate having between 75 and 100 individuals and they ranged from advocates to providers to beneficiaries to State staff and, then, to some of our community partners who are working on Kentucky HEALTH with us.

The other piece that I wanted to highlight are the provider forums that are planned for the spring. We have provider forums starting next month, in April. April 16th is the first one.

April and May, we'll have the provider forums. These are all-day forums. You have another handout in your packet that has the Medicaid spring provider forum and the forum agenda. It's two-sided.

So, the forum schedule has us in April and May at different state park locations across the state, again, to allow for a lot of people to attend in their area.

And, then, the other side on the agenda, it's a full day. This is intended to be the training for Kentucky HEALTH.

The five MCOs will be in attendance at all of the forums. The intent is that the MCOs will be there to provide support and to have

information and for their providers to be able to ask questions of them. They will not be presenting.

We had the request from our providers and from our MCOs that the State Medicaid team would be in charge of providing the same training and information across the board so that everyone hears the same consistent message, and we all agreed that that was the best approach.

The spring provider forum will cover the basics. We also have requested specialized trainings for our dental and optometry groups so that we have some additional information, and we will have some specialized training scheduled for them in March and April as well in advance of the July 1st change in benefits where My Rewards will be used for dental and vision benefits.

And we are all happy to answer questions, but that's a brief summary of where we are with the provider forums, stakeholder forums. Outreach and communications to beneficiaries have begun as well.

MS. ROARK: I have questions about the rewards. I guess with the MCOs, I think with WellCare, and Humana, has any of those changed? Like when you go to your visits, they give you a $20

gift card, you know, the incentives.

MS. PUTNAM: I do, the incentives. The MCOs will still be able to provide incentives. The only requirement that we've worked out mutually is that the incentives that the State is providing through Kentucky HEALTH cannot be the same as what the MCOs are providing.

So, they just have to have a different list of incentives. For example, the My Rewards' account currently cannot be used for purchasing eyeglasses, and a number of MCOs do offer that as an added incentive to beneficiaries. That can remain the same.

So, as long as it doesn't duplicate something that is covered through My Rewards through Kentucky HEALTH, the MCOs can continue to provide incentives.

MS. ROARK: Okay.

MS. HUNTER: And they will continue to have those on their websites.

MS. PUTNAM: They will.

MS. HUNTER: And, of course, on their 800 number, their Call Center numbers, they will be able to explain those as well.

MS. PUTNAM: Right.

MR. MARSH: Going back to the discussion about the potential increase of $75 million to the Medicaid budget, how much of that is state money versus federal money?

COMMISSIONER MILLER: Approximately $22 million in that example would be state money.

MR. MARSH: And how much would you be able to cover of that through the provider tax?

COMMISSIONER MILLER: I don't know that answer.

MR. MARSH: So, really, what you get right down to is that when you think about a $75 million increase, especially as it potentially affects the long-term care facilities, you're really only talking about a couple of million of contribution when you think about the amount of provider tax because you're increasing the rates, the rates that apply to the provider tax, and, then, the provider tax is contributed to the State which they use as part of their money to get the federal match, right?

COMMISSIONER MILLER: And you're right. That would increase the revenue that

would be subject to the tax. The tax on that would be equivalent to, since it's on a patient day, we would have some flexibility there - we'll come up with that answer. I'll see that you get that back.

It won't cover the $22 million but it will cover a portion of it. Yes, it would do that.

MR. MARSH: A portion. Thanks.

DR. ROBERTS: Do you have a known percentage or an estimate on what the State's contribution of the CHIP funding would be?

COMMISSIONER MILLER: That rate starts off initially at a little over 6%.

DR. ROBERTS: Any estimate on real dollars?

COMMISSIONER MILLER: That portion of it is, on an annual basis, the biggest portion of $20 million, for the first nine months, we've estimated that out at somewhere in the neighborhood of $12 to $13 million. Those numbers are real close.

DR. PARTIN: I have a couple of questions. The first one is, has the RFP gone out for the MCOs? You said something at an earlier meeting about that going out in the spring.

COMMISSIONER MILLER: That has not gone out yet. We are still evaluating that and working through that. That has not gone out. And keep in mind, some of the things that I touched on, the legislation, all of that has an impact as well. So, we'll have to evaluate that process, depending on what takes place in terms on legislation. No, it has not gone out yet.

DR. PARTIN: And the second question, I was just curious. What is the rationale for reimbursing rural versus urban differently?

COMMISSIONER MILLER: Historically, within the medical cost, the thought is that the cost incurred in the rural areas of the state are different than what you see in urban. That premise is based upon also some of the CMS guidelines as well in that they make a distinction of the medical costs incurred for rural versus urban. So, traditionally the rates have been higher in the urban.

Now, I can speak a little bit more on the hospital side. And as you adjust for like wage index, the cost of labor and other components are generally higher in the urban areas than what you find in rural areas.

Now, having said that, I would also say that that is beginning to blend more together all the time just by the labor force and the requirements and the traveling out of one area to the other, much like what Mr. Marsh touched on earlier.

DR. PARTIN: Right. Right. So, it would seem that maybe that needs to be rethought a little bit? Maybe that's what Representative Meredith was getting at?

COMMISSIONER MILLER: It is something that we constantly look at as far as the need there.

We don't have that many where there's a difference between urban versus rural within the traditional Medicaid Program. We have some. Nursing facilities are one. So, by using the federal approach on the hospital payments, that's another area as well; but for the most part, we have one constant rate across the state. So, that's something that we constantly monitor.

DR. PARTIN: Okay. Thank you.

DR. COMPTON: I have a question or a comment or both actually. It's my understanding at the stakeholder presentations that anything to do with eyes has been lumped into vision services, and

we're afraid that the My Rewards' members will not realize that that only is for routine services. It's not for red eyes, for glaucoma, for diabetics. Could you change your presentation to reflect that to clear up some of that confusion?

MS. PUTNAM: We absolutely can. One of the things that we are trying to finalize are the different specific services that fall under the medical versus falling under the preventive vision and dental.

That is something that will be shared with beneficiaries, providers, widely shared but we haven't finalized it. We had not finalized it by the first session, but that's good feedback and we will definitely make a distinction for the next one.

DR. COMPTON: Thank you.

DR. PARTIN: Any other questions?

MR. CARLE: Kristi, as far as the cost-sharing component and the deductible accounts, have you nailed down what the actual premiums are going to be as well as what the deductibles are? Can we get that schedule just for knowledge?

MS. PUTNAM: Sure. Absolutely.

The premiums will range, depending on the income, will range from $1 to $15 per month for family coverage. The deductible account is a set $1,000 account that the MCOs will control that is paid by the State. So, it's $1,000 for each individual who is eligible under Kentucky HEALTH, but they, then, get monthly statements to show cost of care. We'll get that information to you.

MR. CARLE: It would be nice to have that schedule for reference.

MS. PUTNAM: Yes.

MR. CARLE: And, then, on the spring provide forums, I didn't get a chance to look at this fully, but it doesn't seem like there's any forums in Northern Kentucky.

MS. PUTNAM: This is just for April and May and we continue on I believe all the way through August for the provider forums.

MR. CARLE: Okay. Great.

MS. PUTNAM: They're not scheduled yet. So, this is April and May.

MR. CARLE: I figured as much but I just wanted to make sure.

MR. MARSH: Commissioner Miller, I know there's some activity going on with

respect to the certificate of need, namely I can think of legislation having to do with the pilot program for short-term rehab. It looks like it is dead.

Does the Cabinet have a position on the possibility that the certificate of need would be eliminated and its impact on the Medicaid Program? You think I'm being funny.

COMMISSIONER MILLER: No. We have not developed that position yet, okay, or we haven't thought through that. Certificate of need has been one that the State has defended long and hard over the years.

As to the elimination of the certificate of need, we as a Cabinet, we've not taken a position on that down the road, what that impact would be. I mean, as I say, we have defended certificate of need. As far as the impact if it's eliminated, that's a whole different area.

MR. MARSH: But I do know that there is some general thought in the Governor's Office that he would prefer to do away with certificate of need, and it would be very helpful if the Medicaid Program would have a position on its impact because I think you and I both know that that

impact could be very significant in the overall scheme of things.

COMMISSIONER MILLER: Yes, sir. I'll take that comment back.

MR. MARSH: I'll help you with it if you want.

DR. PARTIN: Any other questions?

For all of the items that you mentioned about sending, just send it to the whole Council.

MS. PUTNAM: Yes, ma'am.

DR. PARTIN: You don't need to send it just to me first. And, then, the information that Chris requested on those premiums and so forth, just please send that to everybody.

MS. HUNTER: I have a full list and we will work that through Sharley. I apologize. She couldn't be here today. She is ill. So, I will send it back through Sharley to all of you and we'll get Kristi's as well.

DR. PARTIN: Thank you.

MR. CARLE: Just one last question. How are we doing with the setup or the process for certification of these individuals to get

into the program?

MS. PUTNAM: For certification for Kentucky HEALTH?

MR. CARLE: Yes.

MS. PUTNAM: We have been working with our MCOs and with our Medicaid Managed Information System vendor, DXC, to go ahead and do some initial partner integration testing to make sure information is being transferred back and forth successfully.

We did our first transfers last week. We have some adjustments to make. Identifying the individuals through the eligibility system is not a problem. We've been able to successfully do that and now we are just testing to make sure the other systems can receive that information.

So, we will make sure that any of those processes are working and working well before we move forward with any of the program.

MR. CARLE: Do we have the process, though, identified and nailed down in the event that an individual doesn't make certification as to what actually happens with them and how they can go back through a recertification process?

MS. PUTNAM: When you're

talking about certification, are you talking about specifically being eligible for Kentucky HEALTH or are you moving on to the medically frail process?

MR. CARLE: Just Kentucky HEALTH.

MS. PUTNAM: Just Kentucky HEALTH. That actually----

MR. CARLE: Because there are going to be those individuals which you know we talked about. They're not going to pay their premium. They're not going to be looking for a job. They're not going to be doing what you have set out and passed.

So, what is the process? I'm concerned about those individuals that fall out. How are they going to be able to get back in?

MS. PUTNAM: They will be able to get back in through the--that's the technology piece that is being worked on right now. That's Release 2. It's just the My Rewards.

So, there's no technology. At this point, it's not finished. It won't be operational until July 1st for the actual tracking of completion of community engagement and payment of premiums, but all of the eligibility information, all

of those system design pieces have already been done so that we know that the eligibility system, Benefind, is able to properly identify someone who qualifies for Kentucky HEALTH. It's able to identify their premium and what that premium should be and it also is able to identify whether or not they have a community engagement requirement.

The work is continuing on the pieces of the system that we'll need to identify when someone is in suspension, how they get back on from the suspension; but in the eligibility system, that work has been done to properly identify those individuals, and notices of eligibility have already been run successfully to show that those individuals are identified properly. The suspension piece comes again in July.

COMMISSIONER MILLER: It might be helpful to touch on the on ramps.

MS. PUTNAM: The on ramps. The on ramps will be the reentry courses, the health and financial literacy courses that are being designed as part of the online learning management system, as well as opportunities for in-person courses.

So, when someone has a non-premium payment suspension, they will have the option

to pay a back premium, no more than two months of back premium. Then, they also will be able to access either an online or an in-person health or financial literacy course to get them back into the system.

And that part of the system design has actually been created so that the eligibility system will know that they've completed the course. It's automated. It reports back to that eligibility system. The MCO payment gets reported that they've made their back premium payment also through the eligibility system and that individual gets moved back into coverage.

MR. CARLE: And is there, then, a portal for providers to be able to access this information because they're going to be right on the front line? These individuals are going to be saying, what do you mean I've been suspended?

MS. PUTNAM: The information in HealthNet is being expanded to include their active versus suspended status.

Something that we're exploring based on meetings with our Hospital Association and other providers is whether we--not whether but how we can make the information about someone who may be behind on a premium payment or may be in danger of

not meeting their community engagement requirement, how we can share that information as a read-only access so providers can also address it if they have someone standing before them.

MR. CARLE: Thank you.

DR. PARTIN: So, I thought that if somebody didn't make their premium payments that they were going to be suspended for six months; but what I'm hearing you say is that they could make those back payments and not have to wait six months.

MS. PUTNAM: Yes, ma'am, they could. They can wait the six months and reapply and come back into benefits coverage or the early reentry option.

Every time we have a suspension period, we do offer an option for early reentry so that they do not have to remain suspended. So, they can do the premium back payments and they can also take that reentry course to enter benefits earlier than the six-month period.

The same thing with community engagement. They can make up the community engagement hours or they can take a reentry course and come back into coverage earlier than a six-month period.

DR. PARTIN: If they wait the six months, do they have to pay the back premiums at that six months or it just starts over again?

MS. PUTNAM: It just start over again.

DR. PARTIN: And, then, another question that occurred to me when you were speaking about the deductible. Is the purpose of that just so that the patient gets an EOB since the State is paying the deductible?

MS. PUTNAM: The purpose of that is along those lines so that they do understand what an EOB looks like. There's also an intent to cover cost of care. Many times with Medicaid services, there's no provision of anything about what cost of care looks like.

One of the purposes behind Kentucky HEALTH Program is to start providing information that looks more like a commercial or private market insurance plan so that as individuals are able to move into private market insurance through an employer, there is an understanding. There are tools available to them to start being able to work with their parts of the insurance they may not be familiar with.

DR. PARTIN: Okay. And will the providers also get an EOB to see the same thing that the patient is seeing?

MS. PUTNAM: We have not considered that but we can certainly consider that.

DR. PARTIN: And, then, one final question. For the reentry, you're talking about doing something on the computer. Is there some accommodation for people who can't read?

MS. PUTNAM: There is. They will be able to work with either an assistor or they will be able to get some assistance through DCBS to be able to take those courses. So, there will be accommodations for those who are not able to read.

DR. PARTIN: And how do they get that accommodation?

MS. PUTNAM: They request it. They would simply request it. Some of the courses are actual videos and we'll have closed-captioning videos and different methods of presenting the information.

We are still working on some of those details as far as providing for different special populations, special-need groups. So, we'll continue to work on that.

DR. PARTIN: Okay. I guess I'm just thinking about some of the people that I take care of and they don't know how to read. And because they don't know how to read, they don't know that these other options are available.

So, if they lapse with their plan, whatever we're calling it, they wouldn't know how to re-engage because they can't read and there's no way for them to get that information.

MS. PUTNAM: We have had a similar conversation with our FQHC's. We've met with that network and they are looking at ways to also provide assistance through their locations as well, but we'll continue to work on ways that we can make sure that those individuals are provided with the services they need.

We are also offering in multiple languages, English and Spanish, but we're working with our refugee partners to see how we can translate additional materials into other languages.

DR. PARTIN: Thank you.

MR. CARLE: We keep saying this is one last question, as I continue to read through here.

So, I'm hoping that you have

some benchmarks or some metrics that you're hoping to actually accomplish.

And what kind of reporting will you do moving forward as far as transparency is concerned because you've got the whole issue of what is My Rewards account and it would be nice for the public to know, okay, how many people and how well they're doing within the accounts or within the path requirement or meeting a deductible account or what kind premium assistance they're getting.

So, just give us a little flavor for what your plans or thoughts are related to transparency and reporting moving forward.

MS. PUTNAM: Absolutely. We have developed metrics. We are in the process of finalizing the metrics for the April 1st release for My Rewards.

We're still working on the July 1st metrics because we want to make sure that we're capturing the right information but not too much or too little.

But for the April 1st release for My Rewards, the metrics that we are looking at capturing is which courses are being accessed, which courses are being utilized the most that we're

providing through the system, what is the average dollar amount that we have accumulated by July 1st because we have opened up the opportunity for people to access preventive services beginning in January.

Also, we turn on the online courses April 1st. So, we want to take a look at what is the preventive service utilization and how many dollars do people earn through that, as well as how many dollars are they accessing through the online courses.

We will be providing that information to all of our partners, the MCOs, the providers, beneficiaries to make sure everyone sees what is the utilization rate for our My Rewards Program.

MR. CARLE: I asked that question for Dr. Liu because he was smiling when I asked that.

MS. STAFFORD: I have another last question. I was just wondering if there's any continued discussions about reimbursement for community health workers?

MS. HUNTER: Yes, ma'am, absolutely there are. We're working directly with Public Health, working with Dr. Connie White, and she

has a team and has actually hired an individual - and I apologize - the name is right here and it will hit me as soon as I go back to my chair - an individual that Dr. White has hired to be over the Community Health Workers Project.

So, we are further along now than we have ever been. We are identifying how we can begin appropriately compensating, and I believe at least one, possibly two of the MCOs are piloting or working on pilots working with Dr. White's shop.

So, we are much further along. It's the right thing to do and we are excited.

MS. STAFFORD: Thank you.

MS. HUNTER: Let us stop on good news.

DR. PARTIN: Anything else?

MR. CARLE: I'll ask you later.

MS. HUNTER: No, Chris. We're here. I'm teasing. You know I'm kidding.

MR. CARLE: The Rewards' dollars for dental and vision, are they on the same platform as for medical? So, they would equal? Rewards for medical are counted as the same for vision and dental? It's a one-to-one?

MS. PUTNAM: The rewards'

dollars--you mean for accessing preventive services?

MR. CARLE: Yes.

MS. PUTNAM: They vary. So, the rewards' dollars vary. For example, it's $100 for someone who goes to get a health risk assessment. The rewards tend to be higher for the preventive services because we definitely want to incentivize preventive care; but the courses, the online courses will be set values for the initial release April 1st.

The Executive Project Team staff have decided what the values should be, but going forward, we are in the process of developing an advisory group that will help with the My Rewards.

We probably would like to have participation from this group. So, we may follow up with that but it will be different dollar values depending on the activity.

MR. CARLE: The reason I ask, 10% of most hospitals' emergency visits are related to dental issues. So, I wanted to make sure that there was the potential of getting equal value of My Rewards for dental services as well as health services, and I'm sure that the Dental TAC feels the same.

MS. PUTNAM: So, provide a

higher incentive dollar for those dental preventive services.

MR. CARLE: Right.

MS. PUTNAM: Okay.

DR. PARTIN: Okay. Thank you. We'll go back to the minutes.

The minutes were sent out in January, but if you haven't had a chance to read them, we can defer that approval until next meeting, if that's your pleasure. Yes?

So, at the next meeting, we will approve the minutes for January and March, today.

So, moving along, we will go to the reports from the TACs and we'll start out with Therapy Services. Primary Care.

MR. BOLT: David Bolt for the Primary Care TAC. We have a note in your packet. No additional recommendations. In fact, it was a pretty good month. A lot of cooperation, a lot of good things going on and some very forward movement. Thank you, Commissioner. Thank you.

DR. PARTIN: Podiatry. Physician Services.

DR. McINTYRE: Hi. I'm Dr.

William McIntyre, Vice-Chairman of the Physicians TAC.

We had a meeting a week ago. We had a quorum. First of all, I want to thank Commissioner Miller, Deputy Commissioner Hunter and Kristi Putnam, the Program Manager for Kentucky HEALTH for their attendance and participation at our meeting. It was very helpful.

We discussed, as we do at every meeting, the issue of provider enrollment, and we want to thank Medicaid for the work they're doing on pushing that forward. We're going to continue having the enrollment issue as a standard agenda item at our meetings.

We received an update on the 1115 Medicaid Waiver Program from Kristi and we want to thank her for that.

There was discussion about the tobacco cessation CPT Code 99406 which wasn't a part of the 2018 Medicaid fee schedule, but the Medicaid executive staff made a commitment to us to include this in the fee schedule.

We discussed translation services and when they're covered by MCOs. It's not currently covered by the Medicaid Program, per se.

This concludes my report. I'll be glad to answer any questions.

DR. PARTIN: Any questions? Thank you very much.

Pharmacy TAC. Optometry.

DR. COMPTON: Yes. Our TAC met on February 22nd. All of our TAC members were there. All the MCOs and their subcontractors were there except Anthem and EyeQuest, and I understand that was not intentional. There was just a mixup on the date.

We held elections and we've set our dates for the rest of the year. So, we're now compliant with all the bylaws that we put in at the last meeting.

We discussed various billing issues, and DMS furnished us with the process of filing appeals and grievances and so forth through the MCO first and then with DMS.

We discussed the possibility of getting all the subcontractors using the same coding system. Some are following the CPT guidelines as written. Some have interpreted it a different way and it would be nice to get a uniform coding system. And we've identified some of the reasons why and we'll try to offer some solutions at the next TAC

meeting.

Most of our time was spent discussing the upcoming My Rewards Program and how it will work and who will be eligible, and there's still a lot of confusion over what's considered routine care and what's considered medical care.

We have no motions to offer at this meeting and our next meeting is May 10th. Thank you.

DR. PARTIN: Thank you very much. The Nursing TAC did not meet. Intellectual and Developmental Disabilities. Hospital TAC.

MR. CARLE: I'll report for the Hospital TAC.

We had a meeting scheduled; but with all the work that the Cabinet was doing, it was decided that we would cancel that meeting due to their workload and what they're trying to prepare for.

We do not have anything really new to report. We are discussing the waiver with the Department, the issues and challenges that it presents to us and we are following the DSH bill very, very closely and waiting for Senate approval. So, that's it. No recommendations at this time.

DR. PARTIN: Thank you. Home Health.

MS. STEWART: The Home Health TAC met on February 27th. All members were present and we have no recommendations at this time.

DR. PARTIN: Thank you. Nursing Home.

MR. TRUMBO: The Nursing Home TAC has got inquiries out to three individuals or multiple individuals about filling three of their open positions.

I'd also like to advise the Cabinet that the 2017 Aon Study has been released and we'll get them a copy of that. Kentucky has improved to third worst in the nation on loss rates for liability insurance and just a reminder that it doesn't appear any tort reform is going to pass this legislative session. So, pressure is continuing to build. Thank you.

DR. PARTIN: Thank you. Dental TAC. Consumer Rights and Client Needs.

MR. SCHULT: Everybody wants to hear more from Dr. Schuster, so, I'd like to invite her up early to help because she's helped me get this restarted.

Anyways, we were able to save or the TAC is not being eliminated like we thought it was going to be, so, that's good but we're trying to get it restarted.

There are five organizations that have to, or by statute, are supposed to nominate members. One of them doesn't exist anymore, but Dr. Schuster was able to get the other four to give us names of individuals that will be on the TAC.

So, our goal is to have a meeting for this TAC before the next MAC meeting and have elections and meetings set up.

DR. PARTIN: Thank you. Children's Health.

MS. KALRA: Hi. I'm Mahak Kalra. I'm the Co-Chair of the Children's Health TAC. We actually met on Wednesday, March 14th. Unfortunately, we did not have a quorum, so, we could not vote on our meeting minutes or make any recommendations but we had great discussion. So, I'm happy to share any of our discussions.

DR. PARTIN: Thank you.

MR. CARLE: We know that feeling very well.

DR. PARTIN: Behavioral Health.

DR. SCHUSTER: Good morning. I'm Dr. Sheila Schuster, Chair of the Behavioral Health TAC. Five of our six members were present at our March 6th meeting, also five MCOs, Medicaid, Behavioral Health and many members of the behavioral health community.

With the approval of the 1115 Waiver, we were again very concerned about the definition of medically frail and we're most grateful that Dr. Gil Liu, who is the Medical Director for DMS, came to talk to us about that, and joining him in that discussion was Dr. Allen Brenzel, who is the Medical Director for the Department for Behavioral Health, Developmental and Intellectual Disabilities.

We understood from that discussion and the question-and-answer portion of the presentation that several categories such as recipients of SSI and SSDI and those deemed to be chronically homeless were automatically included in the definition.

Others would be determined through an analysis of claims data, while others could be included via an attestation made by a Medicaid-approved provider who was working with that individual.

There was quite a bit of discussion and feedback given to Dr. Liu and Dr. Brenzel about the length of the attestation form and the demands on the provider in filling it out.

Dr. Liu indicated that it was in its final stages and he would be distributing it to us and to the provider community for further feedback. He also indicated that the time the provider spent filling out the form would be a reimbursable service.

The discussion helped many of us better understand the medically frail category and to get a better handle on the criteria. As you all know, this is, particularly for behavioral health, is such an incredibly important issue because it's the definition that includes those with serious mental illness and those with substance use disorders which are many of our folks that we're concerned about and those with acquired brain injuries.

Being in that category means they don't have to pay premiums and they don't have to participate in the work and community involvement requirements, and their full range of benefits including full range of dental and vision are included.

So, we are advocates, to say the least, about making sure we understand what medically frail means and that we make sure that everybody who should qualify gets into that category so that we can understand it.

We raised the question as to whether it would be possible to have a sixty-day grace period during which a Medicaid member or applicant would be going through the determination process for categorization as medically frail.

We don't want that person to assume to be in Kentucky HEALTH and then get dinged for not doing the work and community involvement if, in fact, they have a good chance of being in the medically frail category.

Dr. Liu and Dr. Brenzel indicated they would be happy to meet again with us as the process gets more formalized, and we are certainly grateful to them for their time and expertise.

A question was asked of Dr. Brenzel about the current IMD exclusion - that's not the one that's in the waiver but that's the one for psychiatric services - and the fact that two MCOs are doing it and one is getting ready to implement it.

The language around that IMD exclusion is permissive for the MCOs to participate, and, of course, we would like to see all five of them participate in that.

Dr. Brenzel then indicated that the 1115 Waiver also includes an IMD exclusion of thirty days in a facility larger than sixteen beds for the treatment of substance use disorders, and there would probably need to be a certification of the facility probably through KARF or JCAHO.

The overall goal as he indicated was to provide treatment on demand for those with SUD, and we certainly support that. We want to make sure that our folks, whether they're in acute phases or whether they're chronic in terms of their substance use disorder, do get into treatment.

Discussion then moved to a question about a provider being put on prepayment review. Four of the MCOs have such a mechanism and the other MCO does it retroactively, and we were directed to the part of the existing contracts between DMS and the MCOs that have that language.

A question had been posed about a change in the prior authorization procedure for some antipsychotic medications, both oral and injectable. And you all have heard from me

repeatedly the difficulty of our folks not getting their medication when it's been prescribed and is appropriate and they need to stay on it because what happens - and we have this from consumers themselves but also from family members - they go to the pharmacy and they're told there's been a delay.

It matches the voice in their heads, quite frankly, that they shouldn't be on this medication to start with and then they're off their meds and their down into that revolving door, in and out of the hospital and in and out of homelessness and jail.

Only one MCO had recently changed their procedure and it was not clear that the change had been submitted to DMS for approval. The MCO will do that, as well as to contact the psychiatrist who brought forward the problem.

And we are very grateful to Stephanie Bates for helping to explain that and to offer her assistance in that process.

We're also very happy to get the reports from Navigant through Lori Gresham of the 1915(c) Waiver discussions.

Advocates and providers of brain injury services discussed the fact that no new

slots were put in the proposed budget for the upcoming biennium and sixteen long-term slots which were designated in the current budget were never funded. I noted that the Senate budget which was just passed a couple of days ago does have funding for those slots.

You all may remember that we talked about this before. There are over 8,000 people in Kentucky who are on waiting lists for those various 1915(c) Waiver slots and they run the risk of being put in a very costly institution if we can't get these community-based services to them to allow them to remain in the community.

We do make this recommendation to the MAC because of the large number of individuals with acquired brain injuries who are being turned down for services because they have a substance use disorder which is not uncommon for those with this kind of injury. Others are being denied services because they have a concussion which doesn't make a lot of sense to me.

So, our recommendation is that an appeal from denial of a service or services by the Medicaid 1915(c) Waiver for medical necessity, or denial, limitation, or determination of service in a

case involving a medical or a surgical specialty or subspecialty, shall, upon request of the recipient, authorized person or provider, shall include a review by a board-certified brain injury physician such as a physiatrist, a neuropsychologist or an APRN specializing in brain injury or the appropriate specialty or subspecialty area.

The reviewer shall not have participated in the initial review and denial of service and shall not be the provider of service or services under consideration in the appeal.

This goes back to something that we've been here and had recommendations for at least the last two MAC, maybe the last three from the ABI community and that is that they don't feel like there are qualified people that are making these decisions at the Cabinet level about what is appropriate for rehab services for persons with acquired brain injuries.

An issue was brought forward on the conflicting regulations regarding substance use services between a BHSO, an AODE and Medicaid. We formed a small task force to look at those regulations and to make recommendations to the TAC for their consideration. I think we heard that from

Kristi about different definitions or maybe it was from Jill about the waivers and different definitions and this is happening with SUD.

Since our meeting, one of our TAC members representing the Brain Injury Alliance of Kentucky has resigned and that organization has named Diane Schirmer to be its representative. That information has been forwarded to DMS.

And the next meeting of our TAC will be held on May 1st at 1:00 p.m. in Room 125 of the Capitol Annex.

I do want to thank Bill Schult who has worked with me so closely in trying to get the Consumer Rights and Client Needs TAC up and running. We did save it from the trash bin. We got it removed from the legislation that was going to deep six it.

And the Cabinet was very responsive to when I said we were trying to get it up and going, and we should be able to submit the names of four out of the five members and hopefully we'll have a report for you at the next MAC meeting.

I'm happy to answer any questions.

DR. PARTIN: Thank you. So,

moving along to New Business, we just have one item that I wanted to bring forward. And if anybody else has anything else they would like to bring forward, please do so.

We have found, and I've heard this from other people as well, that the MCOs when they are requesting information from the practices to monitor the quality measures, they're requesting encounters for the whole year on multiple patients.

And for our practice, one MCO requested records for a whole year on fifty-four patients. You can imagine the amount of paper that was because they wanted every encounter regardless of what measure it was that they were looking for.

I'm not sure what measure they were looking for, but that's a lot of paper and that's a lot of work because we use electronic records. So, we have to download the encounters and then print them all.

So, I was wondering if there would be something that could be done about that, about that request.

COMMISSIONER MILLER: In the short run, in the short run, we will look at that. I hear you loud and clear on the number of fifty-four

and what takes place and all the different details there.

Clearly, no, we've got to be able to monitor the quality of that, but it seems a little excessive but let us deal with that.

DR. LIU: Two things. One, I just wanted to make you aware of something called the Performance Measures Alignment Committee.

This is a joint effort by the Kentuckiana Health Collaborative, a large consortium of employers for the state, auto manufacturing, package delivery and logistics and the Cabinet.

There are four subcommittees in that alignment effort - behavioral health, adult health, acute care, children's health - and we're working to look at Medicaid quality measures, Medicare quality measures, commercial measures and bring a core set for us to focus on.

One of the clear goals is to reduce hybrid measures which are the ones that you're referring to that require extra chart review.

So, the work of that committee is going to enter its final phases by June, and I think you will be pleased with the focus and the streamlining. It's very much being done to help

providers not have to do any extra work to demonstrate quality.

One other just reference I'll make is right now, our managed care organizations are reviewed by the NCQA which uses HEDIS in order to credential them at various levels of performance.

So, they are beholden to this national accrediting body that does include hybrid measures and that's one of the areas of difficulty in getting out from underneath that requirement, but I did just want to let you know we're focusing very hard on that and we hope to have something specifically to you by the summer.

DR. PARTIN: Okay. Great. Thank you. Dr. Liu, while you're there, I was going to ask you. On the form for the medically frail, could you provide that working draft to the MAC so that we can take a look at that?

DR. LIU: So, I'm going to give you a tentative date and an invitation.

So, the history of the provider forums is they heavily have been attended by practice managers and kind of the business associates of medicine and we've struggled to get clinicians to attend.

In light of the 1115 Waiver, we are desperate to get clinicians to attend these forums. And if you look at the agenda, I hope you'll see that we've designed the morning to be clinician-focused.

We want to release the medically frail attestation form after the first May forum so that we can incorporate input we get from the providers before finalizing that document and that's why we haven't shared it yet. It hasn't gone through its final phases of revision.

So, I'm sorry to have not delivered that to you. I am really hoping and planning on getting a lot of input through these in-person exchanges, and the expectation, I believe, is to have that delivered by the second Monday in May.

DR. PARTIN: So, what I'm asking is that could we see it before it's finalized so that we could have input?

DR. LIU: I think right now, the decision by DMS is to withhold it until we have a more final version. I'll defer to the Commissioners in that regard.

MS. BATES: We'll go over it in the forums.

DR. PARTIN: So, no? Is that the answer, no?

MS. BATES: The answer is no for today, but we are going to talk about it during the forums, the spring provider forums. So, that's when we're going to present the whole medically frail process including the attestation and take those comments that we get from providers during those forums and incorporate them into the document.

So, we don't want back at DMS to finalize anything until we've presented and received the input from providers on that attestation.

DR. PARTIN: I understand that, but we won't be at those forums. So, I'm wondering if we could have some input into that before the document is finalized?

MS. BATES: You're welcome to provide any input now. The problem is that we are still tweaking the form, for lack of a better word, during meetings. So, we can take that back to the executive team but we are literally still working on the document.

DR. PARTIN: Right, and I understand that and that's why I'm asking that we

could be involved because we're supposed to be advisory to you. And, so, I'm wondering if we could be advisory to you on this form. I don't mean to be difficult.

MS. HUNTER: No, that's fine. I think it's a good idea. I appreciate the input. Stephanie does great things and that's why I sent her up here and said you've got this, go on, and, then, I didn't think about the next question.

So, let's do this. Here's a good suggestion, thanks to Dr. McKinley for whispering it in my ear. At the same time we're going to release it, could we release it to you all at the same time for your input, so, as we're releasing it out to the forums?

What we're trying to do is avoid sending out a document that somebody has got a document that's going to be changed. So, we don't want to do that to anyone.

So, as we release it out to the forums, we'll release it out to the MAC in its entirety and we'll take your comments at the same time we take provider comments. Will that work?

DR. PARTIN: Sure.

MS. HUNTER: Okay. We'll do

just that.

MR. CARLE: While you're there, on a different subject, you were kind enough to give us the questions that we asked for in the agenda, on the pre-agenda related to the public forums.

MS. PUTNAM: Yes.

MR. CARLE: But there's no answers attached to it. So, it would be nice to have the answers associated with them, like a Q & A.

MS. PUTNAM: Yes. We will get those to you. I do apologize. That got collected and sent to me late last evening because it had not been rolled up yet. So, we can provide the answers with that as well.

MR. CARLE: Great. Thank you very much.

DR. PARTIN: So, when is the meeting, the forum?

MS. BATES: The first forum is April 16th.

DR. PARTIN: Okay. So, that's when we'll get the----

MS. HUNTER: Yes, ma'am.

DR. PARTIN: So, on April 16th, we'll get that.

MS. HUNTER: Or before. Once they're out on the road with a finalized document. I'm hearing from the front row telling me or before. So, as soon as it's finalized to share out there, you will get your copy.

DR. PARTIN: Okay. Thank you.

MS. ALDRIDGE: Dr. Partin, when you were speaking about the fifty-four medical records, I wanted to ask the Commissioner.

When you talk to the MCOs, in our industry, the DME industry, last quarter, some of our members called and they were getting from one MCO a request - and I'm not exaggerating - 364 records. One company got 283. I mean, they were an enormous amount of audit requests and gave them thirty days to get those turned in or the money was going to be recouped.

And when they called their MCO representative that's supposed to help us, he said it was out of his hands. He couldn't control it and there was no change and that you had to either get it done or not get it done.

So, I think that's an extreme number of audits for a one-month period per company that's being requested, if there's anything you can

do to help us with that.

COMMISSIONER MILLER: Send me a copy of the request and let us look at that. I hear you.

MS. ALDRIDGE: Okay. I'll be happy to do that. Thank you very much.

DR. PARTIN: Any other questions? We thank you.

So, if we have no other business, does somebody want to make a motion to adjourn?

MS. ROARK: I have some questions.

DR. PARTIN: Okay. Go ahead.

MS. ROARK: I don't know if all the MCOs are here today but I didn't make it to the last Medicaid meeting but I have brought up Casey's Law in the past.

I have some parents and stuff asking about Senate Bill 192 that allows Medicaid to pay for the rehab or underneath Casey's Law. Transitions and St. Elizabeth, I think, are some rehabs and they're not. Medicaid says if you've filed a Casey's Law, we're not going to pay for the rehab.

I don't know who would address this, the MCOs in the room, if that's true or false or if there's been changes because, in the past, I had Casey's Law done on my daughter and I didn't pay anything and now I've come to find out that if you do an evaluation at Mountain Comp or Bluegrass.org, you're going to be charged $300. It's not no longer going to pay for those evaluations.

COMMISSIONER MILLER: Bear with me a second.

MS. HUNTER: Thank you so much. Could we possibly get examples of those claims or of those authorizations that are being denied? Could I touch base with you, Stephanie and I touch base with you afterwards and if anyone else wants to share examples as well?

MS. ROARK: Yes.

MS. HUNTER: Share examples with us and we'll take them back and we'll share them with the appropriate MCOs and ensure that we know what claims you're talking about or what auths and get that out to you.

MS. ROARK: Thank you.

MS. ROARK: And as you know, my daughter is almost--well, she's six months pregnant

and they've come out with laws if someone is on drugs, that they automatically take the rights. I'm wondering, as a grandparent or a caregiver, is there any help or resources if you had to raise your grandchild?

MS. HUNTER: With regard to Medicaid, I know that we can speak to health coverage. If the child is in your home or if the child was in the biological mother's home, no matter what situation, if the child is eligible for Medicaid, based on the situation in which it resides, you can certainly apply for Medicaid for the child.

MS. ROARK: Okay. Thank you.

MS. HUNTER: Yes, ma'am. And if we can help with any other resources in the Cabinet, let me know.

MS. ROARK: Okay. I appreciate it. Thank you.

DR. PARTIN: Any other questions? Motion to adjourn?

MR. MARSH: Move to adjourn.

DR. PARTIN: So moved. Thank you.

MEETING ADJOURNED