CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

March 28, 2019
10:00 A.M.
Room 171
Capitol Annex
Frankfort, Kentucky

MEETING

APPEARANCES

Elizabeth Partin
CHAIR

Chris Carle
Julie Spivey
Steven Compton
Melody Stafford
Jay Trumbo
Ashima Gupta
Bryan Proctor
Sheila Currans
Stacey Watkins
Susan Stewart
Jerry Roberts
Teresa Aldridge
COUNCIL MEMBERS PRESENT

AGENDA

1. Call to Order 3

2. Approval of minutes from January meeting. 3

3. Old Business
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   B. Update from opinion from Attorney General on video teleconferencing ... 10 - 11

4. Updates from Commissioner Steckel......... 11 - 25

5. Reports and Recommendations from TACs
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   *Nursing Home Care .... (No report)
   *Home Health .... (No report)
   *Hospital Care .... 38 - 40
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1 DR. PARTIN: Good morning.
2 We'll go ahead and get started. Everybody, if you
3 would please remember to turn on your microphone when
4 you speak so that our transcriptionist can hear what
5 you say.
6 The first item on the agenda is
7 approval of minutes from the November meeting.
8 MS. HUGHES: Beth, I think
9 that's actually supposed to be January. I just
10 realized that.
11 DR. PARTIN: Okay. I just
12 assume that you're right, Sharley.
13 MS. HUGHES: Sorry about that.
14 DR. PARTIN: So, I stand
15 corrected.
16 MR. CARLE: I make a motion
17 that we approve the January meeting minutes.
18 MR. TRUMBO: Second.
19 DR. PARTIN: Any discussion?
20 All in favor, say aye. Opposed? So moved.
21 We'll move on to Old Business.
22 First on the agenda is the memo sent from the
23 Commissioner back in January regarding the TAC
24 meetings and how those meetings will function.
25 And as a result of that memo, a

1 workgroup was formed consisting of some members of
2 the MAC and all of the TAC Chairs.
3 So, I'm going to assume that
4 all of the TAC members here and all of the MAC
5 members here are aware of the items that was in the
6 Commissioner's memo. Is that correct? Okay. So, we
7 don't have to go over that.
8 The workgroup did come up with
9 some recommendations and I will read those so that we
10 have those in the transcription of the meeting.
11 The Medicaid Commissioner sent
12 a directive to the Medicaid Advisory Council (the
13 MAC) and the Technical Advisory Committees (the TACs)
14 regarding how she believes the TACs should conduct
15 their meetings and where the meetings shall be held.
16 A workgroup consisting of some
17 members of the MAC and the TAC Chairs was formed to
18 address the Commissioner's directive.
19 KRS 205.540(4) states that the
20 MAC shall adopt rules governing its procedures. This
21 statute clearly grants authority to the MAC to set
22 its own rules.
23 There's no reference in the
24 statutes for the MAC or the TACs that would give the
25 Commissioner authority over them either to cancel

1 their meetings or to dictate their agenda or to try
2 and micromanage their operation.
3 Therefore, scheduling of
4 meetings, the MAC bylaws stipulate that the TACs may
5 schedule meetings with thirty days' notice and that
6 the TACs do not need to schedule a year's worth of
7 meetings. The open meetings' statute requires a two-
8 week notice.
9 Issues may arise and a TAC may
10 want to schedule a meeting to discuss the issue.
11 However, if a TAC chooses, they may schedule their
12 meetings for a full year.
13 Agenda. The MAC bylaws do not
14 require the TACs to provide the agendas two weeks
15 prior to the TAC meeting. The MAC is required one
16 week in advance, according to the bylaws, and the MAC
17 Chair is supposed to provide an agenda two weeks
18 prior to the MAC meeting.
19 Cancellation of meetings. The
20 MAC bylaws do not allow for DMS to cancel a TAC
21 meeting or a MAC meeting due to the agenda not being
22 provided.
23 TAC meeting minutes. For the
24 past year, DMS has paid a court reporter to be
25 present at TAC meetings. This produces a long

1 verbatim report of the meeting which can run as long
2 as a hundred and fifty pages. This seems a waste of
3 money. The TACs are capable of taking their own
4 minutes and should do so. This would save DMS money
5 which could be used in more productive ways. The TAC
6 meeting minutes may be provided to the MAC as well as
7 any recommendations.
8 TAC recommendations. TACs may
9 provide some background information to the MAC in
10 addition to recommendations. The background
11 information is sometimes helpful to the MAC and to
12 members of the public who are in attendance at the
13 MAC meeting.
14 If time is running short at a
15 MAC meeting, the MAC Chair may request that TACs
16 present only their recommendations so that the TACs
17 may have time to give their reports.
18 Topics for TAC meetings. The
19 TACs should be able to discuss anything a TAC member
20 wants to bring forward at their meeting. While
21 individuals may be the only one with reimbursement or
22 other issues, by bringing it up at a TAC meeting, a
23 broader issue may be identified. Other members of
24 the TAC may be having the same issue.
25 Likewise, TAC members should be

1 abler to discuss at their meeting any problems they
2 are having with an MCO. MCOs are invited to TAC
3 meetings and issues may be remedied at that point
4 rather than having to bring the issue to the MAC.
5 Location of TAC meetings. TACs
6 should be able to meet in the Capitol Annex or any
7 other public location that is easily accessible to
8 the public and TAC members. Parking is convenient at
9 the Annex and rooms easily accessible. The location
10 proposed by the Commissioner is not easily accessed
11 and parking is difficult.
12 Attendance at TAC meetings by
13 DMS staff. While DMS staff is certainly welcome to
14 attend any of the TAC meetings and most TACs find it
15 helpful to have DMS staff present, they should not be
16 required to attend.
17 And that is the complete report
18 from the workgroup. So, having read that into the
19 record, I would like to ask if any MAC members have
20 any comments that they would like to make?
21 DR. ROBERTS: I was not part of
22 this task force, but one of the guidelines that was
23 kind of set forth by the Commissioner was that this
24 forum was a platform for advising Medicaid on policy
25 issues.

1 When we look at barriers to
2 care and quality of care delivered to the Medicaid
3 recipients, one of the common things we find are
4 either for physicians that don't participate in
5 Medicaid or limit the number of Medicaid recipients
6 that they will take.
7 At least from my discussion
8 with some other practices and providers, there are a
9 couple of things. One is reimbursement issues or the
10 amount of reimbursement. Obviously, DMS has a
11 limited budget. I'd love for you guys to have an
12 infinite budget and that would solve a lot of
13 problems.
14 Number two are the number of
15 PA's involved, and number three are the denials.
16 So, when you talk about policy
17 decisions, improving the quality and access of health
18 care to these recipients, that goes hand in glove
19 with fixing the reimbursement and the billing and the
20 denial issues. So, I think it's very difficult to
21 separate those two.
22 Now, I agree. The entirety of
23 every MAC meeting and every TAC meeting should not
24 all be about why didn't I get paid for this wound
25 debridement in November of last year; but when it

1 impacts the delivery of care to such an extent, you
2 have to have some reimbursement, some improvement in
3 the billing, coding, reimbursement and review process
4 as part of the discussion of public policy.
5 The other comment that I would
6 make - and this has been, unfortunately, an
7 escalating tone in the recent MAC meetings - I'm one
8 of the younger ones, I think, on the MAC - but I've
9 sat on a number of hospital state and national
10 committees.
11 When you bring different
12 stakeholders, different specialists, lay people all
13 together in the same room, Napoleon Hill talks about
14 a definitiveness of purpose and building your
15 mastermind alliance, and that's exactly what the
16 mandate of this Board is.
17 When you bring all these
18 people, when you put them around a table, all the
19 credentials, all the echos go out the window. When
20 you're working hard to fix a specific problem, then,
21 the authority doesn't really matter so much.
22 If we define exactly what this
23 Board is set out to do, then, that solves a lot of
24 the problems we're talking about.
25 DR. PARTIN: Thank you, Dr.

1 Roberts. I think those points are well-taken. Any
2 other comments?
3 So, moving forward, we need to
4 make a decision as far as the function of the TACs
5 and how the TACs will conduct their meetings.
6 And, so, is this Council in
7 agreement with the recommendations from the
8 workgroup?
9 MS. CURRANS: Do you need a
10 motion to accept the recommendations of the
11 workgroup?
12 DR. PARTIN: Yes, please.
13 MS. CURRANS: I'll make that
14 motion.
15 MS. ALDRIDGE: Second.
16 DR. PARTIN: Any further
17 discussion? All in favor, say aye. Any opposed? So
18 moved.
19 So, moving forward, the
20 recommendations from the workgroup will be
21 implemented as far as the functioning of the TAC
22 meetings.
23 Next on the agenda is an update
24 on the Opinion from the Attorney General regarding
25 video teleconferencing.

1 So, just to give you a little
2 bit of an update, our Secretary, Teresa Aldridge,
3 wrote a letter to the Attorney General requesting an
4 Opinion on behalf of the Council, and the Attorney
5 General's Office responded saying that we had to have
6 a letter coming from the Chair of the Council rather
7 than the Secretary requesting that Opinion.
8 So, I did write a letter and
9 submitted it to the Attorney General. And I checked
10 the status of that yesterday and the Attorney
11 General's Office said that an Opinion was still
12 pending and that I should check back in about two
13 weeks. So, hopefully we'll have an Opinion by our
14 next meeting.
15 Next on the agenda, updates
16 from the Commissioner.
17 MS. BATES: Good morning. So,
18 obviously, I'm not Commissioner.
19 DR. PARTIN: Good morning.
20 MS. BATES: Stephanie Bates,
21 Deputy Commissioner of Medicaid.
22 So, just very quickly, I'm just
23 going to give a quick 1115 Waiver update. I'm sure
24 none of you heard but we did get a decision late last
25 night, so, it was a long night which is part of the

1 reason why the Commissioner is not here.

2 And just to kind of update,

3 there's I think a call going on with DOJ right now.

4 So, we're kind of evaluating the situation.

5 The good news is that we got

6 this decision two days earlier than the last time and

7 we had a bunch of contingency plans in place. So, we

8 were able to just kind of stop systems for right now

9 and we're meeting all day today to decide what to do

10 going forward as far as the systems but nothing is

11 going to change. Everything is on hold.

12 So, do you all have any

13 questions about the waiver? Okay. Good.

14 Then, I'm going to let Jonathan

15 do a legislative update.

16 MR. SCOTT: Good morning. I'm

17 Jonathan Scott. I'm the Regulatory and Legislative

18 Advisor for DMS. I'm here to talk to you about some

19 of the legislation that was passed.

20 Do you all have any questions

21 about any legislation before we get started? I have

22 quite a few notes. It's whatever is easier for you.

23 DR. PARTIN: Unless anybody has

24 any specific questions, I think it would just be

25 easier for you to go through your list.

1 MR. SCOTT: Sure. Okay.
2 Senate Joint Resolution 7 is a diabetes prevention
3 study. It's going to require DMS to study the
4 potential impacts of implementing programs similar to
5 the KEHP Diabetes Value Benefit Plan or the Diabetes
6 Prevention Program.
7 We're going to look at the
8 estimated cost of the program, the health benefit
9 that this program could give Medicaid beneficiaries,
10 and any potential financial savings.
11 The report needs to be
12 submitted by November 1st of this year. We will work
13 with our MCOs and DMS staff, possibly a couple of
14 other entities to study the impacts of implementing
15 this and we'll submit a report by November 1st to
16 Health and Welfare.
17 MR. CARLE: Jonathan, do you
18 have a little bit more detail, though? When you say
19 implementing this, is it a study on A1c? It just
20 says diabetic-related. We need a little bit more
21 detail.
22 MR. SCOTT: It's just a study
23 of the Diabetes Prevention Program.
24 MR. CARLE: So, Stephanie, do
25 you know any of the program scope or anything?

1 MS. BATES: Basically, we've
2 been asked for several years to cover the Diabetes
3 Prevention Program. I don't remember how long the
4 program is but it's ongoing. Like, it goes over the
5 course of several weeks and it is diabetes education;
6 but to get into the program, you can't already be
7 diabetic. It's kind of like you're in a pre-diabetic
8 state.
9 So, one of the reasons why we
10 haven't just covered it is because, with Medicaid, we
11 have to figure out, just because of the federal
12 rules, which provider type that we have can provide
13 it as far as licensure and all of that and, then, the
14 medical necessity piece because with the person who
15 seeks out the program is not diabetic, so, doesn't
16 have that diagnosis, we're trying to figure out how
17 to cover it.
18 Other states do it. So, that's
19 part of what the study will be is we'll look at other
20 states. We already have an MCO, I think - and don't
21 ask me who - that's doing a pilot.
22 So, I think that's what the
23 legislation was meant to do was to look at all of
24 that, see if it will save us money to prevent
25 diabetes which it sounds like it would.

1 MR. CARLE: Okay. Thank you.
2 MR. SCOTT: Senate Bill 30
3 requires coverage of genetic tests for cancer risk if
4 it's consistent with the National Comprehensive
5 Cancer Network. It also lowers the age for
6 colorectal cancer examinations and first screenings
7 to 45 from 50.
8 That has been signed by the
9 Governor. And going forward, we're going to
10 coordinate with the MCOs to determine the extent to
11 which they will be impacted and coordinate with the
12 Department of Insurance as necessary.
13 DR. PARTIN: So, what type of
14 genetic testing are we talking about?
15 MS. BATES: It was very
16 general. The bill was very general, so, that's where
17 we are is to figure out what the recommendations of--
18 what was the----
19 MR. SCOTT: The National
20 Comprehensive Cancer Network.
21 MS. BATES: So, we have to
22 evaluate what their recommendations are going forward
23 and kind of put that with testing.
24 DR. PARTIN: Would this be just
25 voluntary on the part of the patients if they wanted

1 the testing done? DMS would cover it?
2 MS. BATES: Yes. It would have
3 to be ordered by a Medicaid provider but that's
4 between obviously the patient and the provider.
5 DR. PARTIN: Right. Okay.
6 MR. CARLE: But they would
7 actually cover the cost of the genetic testing.
8 MS. BATES: Right. And, of
9 course, it's not going to be all----
10 MR. CARLE: It will be marker
11 specific, yes.
12 MS. BATES: It's not going to
13 be the whole plethora of genetic testing.
14 MR. CARLE: Specific to cancer.
15 MS. BATES: Yes.
16 MR. CARLE: Great.
17 MR. SCOTT: Senate Bill 54
18 requires insurers to develop processes for electronic
19 prior authorizations. There's limited circumstances
20 where a prior authorization could continue for a
21 year. We're not sure that that's going to be a big
22 impact to the Medicaid population.
23 MS. CURRANS: Can you repeat
24 what you just said? I can't hear you.
25 MR. SCOTT: I don't know what I

1 just said. We're going to develop process--the bill
2 requires insurers to develop processes for electronic
3 prior authorizations. Then, there's limited
4 circumstances where a prior authorization can
5 continue for a year.
6 I'm not totally sure the extent
7 to which DMS or the MCOs will be impacted by this
8 because of some House amendments that were made to
9 that bill.
10 So, going forward, we'll ensure
11 that an electronic prior authorization process is
12 implemented within the Department and the MCOs. We
13 may amend the regulations but these are DOI statutes
14 that we're dealing with here, and the bill will be
15 effective at the end of June.
16 MS. CURRANS: Is this the bill
17 that will keep the MCOs from denying the device
18 separate from the procedure?
19 MS. BATES: No. The takeaway
20 from this bill for us, it sounds like, is that MCOs
21 will be required to allow providers to electronically
22 request a PA.
23 MS. CURRANS: Right. And, so,
24 what is this bill number?
25 MR. SCOTT: Fifty-four.

1 MS. CURRANS: House Bill 54?
2 MR. SCOTT: Senate Bill 54.
3 MS. CURRANS: Senate Bill 54.
4 Was that Alvarado's bill?
5 MR. SCOTT: Yes.
6 DR. PARTIN: My understanding
7 of the bill also is that if something is
8 preauthorized, then, it is continued to be authorized
9 for a year rather than right now what happens is that
10 something can be preauthorized and, then, three
11 months later, it's not.
12 MR. SCOTT: That became more
13 complex with Senate and House amendments to the bill.
14 You will want to check the House Committee substitute
15 on that.
16 DR. PARTIN: Okay.
17 MS. CURRANS: So, can you help
18 me because I believe our Association relayed to us
19 because we had had multiple issues with maybe a
20 procedure doesn't even need a PA but a type of device
21 used within that procedure supposedly did and, so,
22 they could deny the whole procedure because you
23 didn't prior auth the screw.
24 Now, that was supposed to--I
25 thought that was in 54.

1 MR. SCOTT: I don't recall
2 seeing that in 54 but we can review it again.
3 MS. CURRANS: Okay. Thank you.
4 DR. PARTIN: You can go ahead.
5 MR. SCOTT: House Bill 224
6 which the final version of that bill, we have come to
7 understand the problems impacting the DME provider
8 community.
9 In particular, the 21st Century
10 Cures Act has acted as a serious stressor for many of
11 these providers. So, the bill was limited to a
12 specific group of DME codes and services that were
13 impacted by the 21st Century Cures Act.
14 The final version also removes
15 some language about medical necessity and a
16 requirement to purchase medical necessity criteria
17 for DME providers.
18 So, the final version is
19 reimbursement at 90% of the DME fee schedule for
20 about 250 HCPCS codes and it includes certain
21 requirements for manually-priced items that copy
22 current regulatory language and it has reimbursements
23 only provided to in-network providers and it will
24 also be effective at the end of June.
25 Senate Bill 110, this ended up

1 being a clean-up of last year's House Bill 69 for us.
2 In our analysis of that original bill, we had
3 concerns about the ability to quickly or immediately
4 enroll providers for events such as out-of-state
5 transplants.
6 The current statute didn't
7 allow for delays, for enrollment delays caused by
8 external entities such as FBI fingerprint background
9 checks, searches of federal databases and things like
10 that.
11 It also didn't emphasize the
12 differences between enrollment and credentialing in
13 Kentucky. So, the bill will also allow the KHA to
14 expand more expansive credentialing activities.
15 So, going forward on this one,
16 we will be able to retain a federal match to build
17 and operate the Partner Portal. We will continue to
18 implement the Partner Portal Program with the changes
19 from Senate Bill 110 and it will take effect at the
20 end of June.
21 DR. PARTIN: Okay.
22 MR. SCOTT: House Bill 320,
23 this bill establishes a Hospital Rate Improvement
24 Program. So, the hospitals will pay an assessment to
25 the fund that will be used as state matching dollars

1 to draw down federal Medicaid funds.
2 The rate improvement will
3 function to increase Medicaid reimbursement for
4 inpatient hospital services provided to Medicaid
5 recipients. There's formulas and processes to be
6 followed by DMS and participating hospitals in the
7 language.
8 Going forward, we're going to
9 prepare a State Plan Amendment to request federal
10 approval and federal financial participation for the
11 new Rate Improvement Program.
12 We will promulgate
13 administrative regulations to implement this
14 assessment as we go forward and it will be effective
15 at the end of June.
16 DR. PARTIN: Does this affect
17 all hospitals including critical access?
18 MR. SCOTT: Yes, all but
19 universities.
20 MS. CURRANS: I think it's any
21 Medicaid inpatient claim.
22 MR. SCOTT: Then, Senate Bill
23 149 will allow a provider to appeal multiple claims
24 in a single external, independent third-party review.
25 It will also allow for a single administrative

1 hearing for an appeal of the final decision of an
2 external review that involves multiple claims.
3 We have experienced a market
4 increase in expenditures in this program over the
5 previous year. So, we are going to continue to
6 review and report on the--going forward, we're going
7 to continue monitoring these increased expenditures.
8 We're going to conduct a review
9 of our statutes and administrative regulations
10 relating to this program to see what improvements can
11 be made.
12 We will coordinate with our
13 Administrative Hearings Branch at the CHFS to
14 determine the extent to which the administrative
15 hearings can be consolidated. We will promulgate
16 administrative regulations to implement this
17 legislation and any streamlining of processes needed
18 and it will be effective at the end of June.
19 And that's all I've got. If
20 you all have other legislation you wanted to ask
21 about or if I could clarify anything.
22 DR. PARTIN: Anybody? Thank
23 you.
24 MS. BATES: Now I'm going to
25 ask Pam Smith to come up and give a 1915(c) Waiver

1 update.

2 MS. SMITH: I am Pam Smith. I

3 am the Division Director for the Division of

4 Community Alternatives.

5 Most notably, we released the

6 waiver applications for public comment beginning on

7 March 15th. That period is going to run through

8 April 15th.

9 We will consider all of the

10 public comments that were submitted from January 7th

11 which was the original start of public comments all

12 the way through April 15th. Those will be summarized

13 and responded to.

14 Just to highlight the most

15 important changes we made while we paused public

16 comments, probably the most notable is the change to

17 how patient liability will be calculated.

18 So, instead of it being 100%,

19 it will be up to 300% which will change most of the

20 waiver patients to not have a patient liability. I

21 think we're going to have less than twenty people

22 that will be left with a patient liability with that

23 calculation change.

24 We also responded to a change

25 that CMS issued in January around participant

1 satisfaction surveys. So, that was added.
2 Our rate study is coming to a
3 close today. In January, we had fifteen providers
4 take a pilot survey and then we used that survey to
5 form the final survey. That was released on February
6 25th to all waiver providers and it all must be
7 submitted by tomorrow. And so far, we've had a
8 pretty good turnout of responses from all of the
9 waiver groups.
10 DR. PARTIN: Any questions?
11 Thank you.
12 MS. BATES: And that is our
13 update. So, do you all have any questions for me?
14 DR. PARTIN: Stephanie, when do
15 you think we will be hearing more about what's going
16 to happen with the 1115 Waiver?
17 MS. BATES: So, like I said,
18 we're meeting today. We're going to go over just
19 what the actual judgments were. Obviously, the Judge
20 handed down a decision on Arkansas, too.
21 So, we're kind of just trying
22 to look at everything, but as soon as we know, the
23 Kentucky HEALTH website, it's new. This morning,
24 there's a new Kentucky HEALTH website just so you
25 know that looks different. And, so, the updates as

1 we get them will be on there, and we'll let you know.
2 Obviously, I will communicate to Sharley and
3 communicate out to the TACs and the MAC.
4 DR. PARTIN: Is there any
5 possibility that maybe the Council could be informed
6 about things a little bit ahead of time instead of
7 just hearing it in the newspaper?
8 MS. BATES: Sure, but trust me,
9 you found out when we found out last night.
10 DR. PARTIN: Sure, as far as
11 the Judge, sure, but as far as what DMS is going to
12 do?
13 MS. BATES: But, yes,
14 absolutely.
15 DR. PARTIN: Thank you.
16 MS. BATES: Any other
17 questions? Okay. Thank you.
18 DR. PARTIN: Then, we will move
19 on, then, to reports and recommendations from the
20 TACs, and first up today is Behavioral Health.
21 DR. SCHUSTER: Good morning.
22 I'm Dr. Sheila Schuster, Chair of the Behavioral
23 Health TAC.
24 We met for the first time at
25 the CHR Building as directed by the Commissioner; and

1 for the first time since we were constituted, we did
2 not have a quorum and part of that was that we had
3 one of our TAC members who had to stay here in the
4 Annex to monitor legislation, and if we had been able
5 to meet in the Annex could have attended our meeting.
6 And also in attendance were
7 representatives from DMS, from all five Medicaid MCOs
8 and members of the behavioral health community.
9 Pam Smith gave us an update in
10 response to a recommendation made at the last MAC
11 meeting regarding reassessments that overlap or
12 coincide with the waiver renewal date and we were
13 very pleased that DMS responded. That's probably the
14 most response that we've ever had from DMS to look at
15 that issue and to give us some feedback and to tell
16 us that they will continue to look at it.
17 What happens is that if a
18 person is hospitalized or in an institution and their
19 renewal date on their waiver comes up while they're
20 in there, they stand to lose their waiver slot.
21 And these waivers, as you all
22 know, have long waiting lists, so, it's a real issue,
23 and they have been very helpful in letting us know
24 that there is a sixty-day extension that can be done
25 in some of the waivers. And I think one of the

1 things that is happening in the redesign is that they
2 want to make that consistent across all the waivers.
3 So, it would be very helpful for our folks because
4 it's just bad luck, if you will, that they happen to
5 be hospitalized or in an institution at the time of
6 their renewal. So, we did appreciate that.
7 We were given a brief update on
8 the 1115 waiver by Sharley Hughes, and, of course, it
9 was at that time to go live on April 1st.
10 The agenda also had an item
11 about the recent DMS change in reimbursement and the
12 time requirement for therapeutic rehabilitation
13 services.
14 For those of you who are not
15 familiar, TR or day treatment programs are really the
16 mainstay for the treatment that we can offer for
17 people with what we call SMI, severe mental illness.
18 And without any notification or
19 process, we found out in early February that DMS had
20 decided to not only lower the rate for that service
21 but also put a time frame on that it had to be at
22 least five hours a day and most of the TR programs
23 don't have people come. Many of our people cannot
24 participate for five hours a day. It's just too much
25 for them.

1 It was going to put our TR’s
2 out of business, quite frankly. And an agency like
3 Bridgehaven Mental Health Services which has saved
4 the State millions in hospital costs by keeping
5 people out of the hospital were going to have to
6 close.
7 So, there was good news.
8 Because of the outcry, if you will, from the agencies
9 that run those programs, DMS stepped back and didn’t
10 change the rate but at least changed the time
11 requirement and set a rate for under five hours which
12 makes it doable.
13 I pointed out to them that we
14 have lots of expertise at the TAC not only in the TAC
15 members but also in our numerous people that come
16 from the behavioral health community, and this is
17 exactly the way that a TAC, I think, should be used
18 because obviously this recommendation didn’t just
19 fall out of the sky.
20 DMS had to be thinking about it
21 at least the last couple of months of 2018. And if
22 they had come to us with here’s our problem or here’s
23 what we’re thinking about, we could have had a
24 dialogue about that and saved this upset that went on
25 for six weeks, two months and now is going to have to

1 be changed because the MCOs thought they were having
2 to change that billing.
3 And, so, the whole thing is
4 just a mess and I really think we could have avoided
5 some of that. We might not have convinced them not
6 to make the changes but the changes would not have
7 been harmful and we could have explained why it was
8 so important not to have a five-hour time requirement
9 which didn't make any sense clinically for the people
10 that we were trying to serve, so, again, that kind of
11 use of the TACs.
12 We continue to have questions
13 about the medically frail designation. There was
14 some miscommunication about when people were going to
15 be notified whether they had that designation or not.
16 And as I've pointed out to you
17 all before, our clinicians are taking up their time
18 to do these attestations and then they get no
19 feedback about whether the attestation has been
20 received or is in process or has been approved or has
21 been sent on for further whatever. It just continues
22 to be a real problem.
23 The new policy for universal
24 copays which we've expressed our concern about has
25 been in effect for two months, and we are looking at

1 doing a more systematic data-gathering and we will
2 have that report at our next TAC meeting and we also
3 had some input from the brain injury community.
4 Our next meeting is on May
5 14th, and I'm giving you public notice that we will
6 be meeting in the Capitol Annex.
7 I do want to make a point that
8 was not in the recommendations, Madam Chair, and that
9 is that we sent our dates for the year to DMS and the
10 location was listed as the Capitol Annex.
11 And when I indicated to Sharley
12 that we wanted to have our March meeting in the
13 Capitol Annex, she said, no, you can't because the
14 public notice says you're going to meet at the CHR
15 Building and I said that was not my public notice.
16 The notice I sent you was that we were going to meet
17 in the Annex.
18 So, the other thing that's
19 being changed by DMS are the notifications that the
20 TACs are sending not only about the dates but about
21 the locations.
22 So, I'm going to take this as
23 an opportunity to make a public notice that we will
24 be meeting in the Capitol Annex on May 14th at 1:00
25 p.m.

1 MS. HUGHES: Dr. Schuster, just
2 as a clarification, the website is the public notice
3 of the meetings. So, I know you send an email out to
4 your people that usually come to your meetings but
5 that's not what constitutes the public notice for the
6 meeting. It's what is put out on the website for the
7 whole world to see. That's what constitutes as the
8 public notice.
9 DR. SCHUSTER: I understand
10 that. I understand that, Sharley, but somebody at
11 DMS changed the notice that we had sent because if
12 you look at what we sent you, and we've had it on our
13 TAC reports, every TAC meeting is listed as being in
14 the Capitol Annex. So, it was changed. That's my
15 point.
16 So, I'm telling you we're going
17 to meet in the Capitol Annex and I'm giving notice in
18 any way I can and I will send it to you in writing
19 but that's what should be posted on the website.
20 I have no control over what gets posted on the DMS
21 website.
22 MS. CARLE: So, Stephanie. Dr.
23 Schuster, you can't see what she is saying behind
24 you.
25 MS. BATES: I'm saying got it.

1 DR. SCHUSTER: Got it. Thank
2 you very much.
3 MR. CARLE: So, you got it
4 taken care of?
5 MS. BATES: Got it.
6 MR. CARLE: Thank you.
7 DR. SCHUSTER: I appreciate
8 it. My other question is can we all have copies of
9 the recommendations that you gave in the TAC report?
10 Will that we circulated by Sharley to the TAC Chairs?
11 DR. PARTIN: Certainly, yes.
12 DR. SCHUSTER: Thank you very
13 much. We appreciate that committee work. Thank you.
14 DR. PARTIN: Next up,
15 Children's Health.
16 MS. KALRA: Hello. I am Mahak
17 Kalra, Co-Chair of the Children's Health Technical
18 Advisory Committee.
19 Our TAC met on Wednesday, March
20 13th. We did have a quorum. This is a huge deal for
21 us because often at times we don't. So, we're
22 excited that we do have recommendations today.
23 The Children's Health TAC has
24 been discussing or reviewing issues around
25 psychotropic medications among children. For those

1 of you who are not familiar with psychotropic
2 medications, these are medications that could affect
3 mind, emotions and behavior. Typical examples of
4 these are antipsychotics, antidepressants, anxiety
5 medications, stimulants and mood stabilizers as well.
6 In Kentucky, Dr. Lohr's
7 presentation with the DCBS has shared that we are
8 over-prescribing for children, especially those in
9 the foster care system. And, so, we were very
10 concerned when we were hearing this data and when we
11 were having this discussion.
12 And in a way to support
13 Medicaid and Dr. Lohr's efforts towards de-
14 prescribing, we would like to propose developing a
15 best-practice guideline or improve interventions to
16 serve not only as guidelines but just to deter folks
17 from prescribing psychotropic meds as the first-line
18 of defense, and, like I said, first-line of defense.
19 We understand there might be
20 issues where this might be necessary later down the
21 road, but often at times, this is the only thing
22 being prescribed to these young children and we know
23 that there are some impacts to their development at
24 that time as well.
25 So, we would like to propose

1 the following recommendations: To ensure that
2 prescribing psychotropic medications are a part of a
3 multi-modal treatment plan when providing supports
4 for these children. Again, we think that if you are
5 going to prescribe something along those lines,
6 couple it with therapy or other types of
7 interventions that are best practice-based.
8 Also ensure that Medicaid
9 reimburses for children to have access to these other
10 therapies as well. So, an example, applied behavior
11 analysis, that's something that could be used for
12 children with the autism spectrum disorder and other
13 disabilities, as well as occupational therapy to
14 improve emotional and behavior regulation.
15 So, those are some of our
16 recommendations. I apologize that you don't have it
17 in front of you but Sharley does have a copy and she
18 is happy to email those to you. I don't know if you
19 guys have any questions.
20 DR. PARTIN: I do have a
21 question. So, this recommendation or these
22 guidelines for prescribing psychotropics, who are you
23 proposing develop the guidelines?
24 MS. KALRA: DMS, and we're
25 happy to partner with DMS and provide some

1 recommendations. We have studies from Florida that
2 we saw that made sense for us to utilize as a state
3 and we could share those with DMS as well.
4 DR. PARTIN: Thank you.
5 Anything else? Thank you.
6 Consumer Rights and Client
7 Needs.
8 MS. BROWN: Hello. I'm Miranda
9 Brown with the Consumer Rights and Clients Needs TAC.
10 We met on February 19th. A
11 quorum was not present, but the TAC did raise
12 concerns about the medically frail attestation
13 process and Kentucky HEALTH notices.
14 Our members shared that
15 beneficiaries have gone to their providers to start
16 their medically frail process but providers nor
17 beneficiaries haven't heard anything back from the
18 MCOs.
19 And while we understand that
20 this may not be a concern in the near future with
21 yesterday's federal court ruling, the State still has
22 options to appeal the court ruling or reduce benefits
23 through a State Plan Amendment which would maintain
24 medically frail protections as relevant. So, these
25 are decisions that we will be watching closely still.

1 Mandatory copays continue to be
2 a concern for our TAC. More than 140 Kentuckians
3 have reported a number of issues they face with
4 trying to access health care. For example, Medicaid
5 recipients are sometimes turned away for services
6 when their income is below 100% of the Federal
7 Poverty Level despite the policy that those living in
8 poverty cannot be turned away.
9 While this could be due to
10 provider offices not reading the screens properly or
11 not being aware of the income guidelines, the bottom
12 line is that this policy is creating an unwelcome
13 effect which is discouraging the use of important
14 services such as preventive care, chronic disease
15 management, behavioral health and substance use
16 treatment.
17 We also discussed ADA
18 guidelines. Our members have expressed concerns and
19 made recommendations related to making accommodations
20 for disabled individuals to participate in TAC and
21 MAC meetings.
22 While DMS has stated that they
23 will comply with the law, we are still seeking
24 clarification on whether this means that DMS will
25 cover the cost of interpretation and assistant

1 services directly for disabled members.
2 We made no recommendations, no
3 new recommendations due to lack of a quorum, and our
4 next meeting is scheduled for April 16th from 1:30 to
5 3:30 p.m., Eastern Time, but we have yet to determine
6 a location.
7 DR. PARTIN: Thank you.
8 Dental.
9 MS. HUGHES: The Dental TAC did
10 meet. I don't believe they had any recommendations,
11 though.
12 DR. PARTIN: Thanks, Sharley.
13 Nursing Home Care.
14 MR. TRUMBO: We don't have a
15 report because we didn't have a TAC meeting. I am
16 interested to know what the status of a LeadingAge
17 representative is? Can we get the question to that
18 organization?
19 MS. HUGHES: On the TAC?
20 MR. TRUMBO: No. On the MAC,
21 Gary Marsh's position.
22 MS. HUGHES: I did not know he
23 had left.
24 MR. TRUMBO: Well, I don't know
25 what their status is but it's been a few meetings.

1 MS. HUGHES: Until he resigns,
2 he's still an appointed member. You can go by the
3 bylaws that were created and make a recommendation
4 but that's not up to me, or the Department, I should
5 say.
6 DR. PARTIN: I'll send him an
7 email.
8 MR. TRUMBO: Okay. Thanks.
9 DR. PARTIN: Home Health.
10 MS. STEWART: Home Health met
11 on February 19th. We did have a quorum and we have
12 no recommendations at this time.
13 DR. PARTIN: Thank you.
14 Hospital.
15 MR. CARLE: Russ Ranallo could
16 not be here today. He was unable to make it. You
17 have a written report in your packet.
18 Just a couple of things. The
19 TAC did meet on February 26th. A quorum was present.
20 The TAC discussed several issues which have not yet
21 been resolved. These include short-stay inpatient
22 denials, utilization management issues, hydration
23 denials and transportation issues.
24 As Medicaid staff were not able
25 to attend the KHA Psychiatric and Chemical Dependency

1 Forum regarding the transportation issues, KHA has
2 submitted a written report with questions attached.
3 The TAC also discussed the
4 concerns that IPRO should be using clinicians to
5 conduct clinical validation reviews instead of coders
6 and billing specialists. Clinical validation
7 involves a clinical review of a case to see whether
8 or not the patient truly possesses the conditions
9 that were documented in the medical record. DMS will
10 be reviewing their contract with IPRO to address this
11 issue.
12 The TAC also discussed the
13 problem hospitals are having in not being able to
14 bill Medicaid when Medicaid is the secondary when the
15 patient refuses to cooperate with the primary
16 insurer. This issue is also under investigation but
17 has not been resolved.
18 KHA will be scheduling a
19 meeting of hospital medical directors with Dr. Liu to
20 discuss concerns with MCOs not following CMS national
21 definitions and coding requirements for sepsis. We
22 committed to try to work out these concerns before
23 bringing specific recommendations on this issue to
24 the MAC and this is somewhat of a big issue. So, it
25 needs to be addressed.

1 Lastly, one MCO is only giving
2 hospitals twenty-four hours to obtain an updated
3 prior authorization when the CPT code of the
4 procedure performed on the patient differs from the
5 CPT code that was preauthorized.
6 This is unworkable and needs to
7 be changed to address the fact that physicians will
8 not always know the exact code prior to performing
9 the procedure on the patient.
10 In addition, a twenty-four-hour
11 time frame is not a reasonable time frame for the
12 provider to update a CPT code. While seven days was
13 discussed as a minium time frame, KHA is currently
14 requesting the policies for each MCO and will be
15 working with its members to make more detailed
16 recommendations for addressing this issue. That's
17 it.
18 DR. PARTIN: Thank you. Any
19 questions?
20 Next up, Intellectual and
21 Developmental Disabilities.
22 MR. CHRISTMAN: Good morning.
23 I am Rick Christman. I'm the Co-Chair of the IDD
24 TAC.
25 We met on Wednesday, March

1 13th. We did have a quorum. Although we didn't have
2 any specific recommendations to pass, we had a lot of
3 people there and we had a very good discussion.
4 I think I had mentioned in the
5 past that one of the big issues particularly with the
6 SCL waiver is large numbers of people because of
7 their particular medical needs or their behavioral
8 issues are really beyond the ability of the providers
9 to continue to provide services for them.
10 Unfortunately, the way the
11 regulation is set up - and I shouldn't say
12 unfortunately. I understand why this is. Under the
13 regulation, we have to continue to provide services
14 until we can find another provider.
15 Well, as you know, as you can
16 imagine, this really makes providers unwilling to
17 really serve people who they might suspect would be
18 difficult to serve. So, this is an ever-growing
19 problem. It's kind of freezing up the system.
20 I think we've already
21 identified 150 providers who felt they are serving
22 people that they really can't meet their needs which
23 is not a good situation for anybody.
24 However, at this meeting and at
25 this long discussion, Commissioner Steckel was there

1 which we were very happy to have her there, and as a
2 consequence, we have formed a task force to look at
3 this issue along with Pam, anywhere between ten and
4 fifteen people and we hope to get started with those
5 meetings right away to see if we can resolve this
6 process.
7 As Pam also mentioned, the
8 applications for the 1915(c) Waivers are out and
9 we're looking at that, but the one thing that she
10 mentioned that we're all delighted about is the
11 increase of the patient liability to 300% of poverty.
12 That's huge for us and very welcomed.
13 And in closing, I just want to
14 say I really feel like our TAC has been
15 reinvigorated. I think the fact that the
16 Commissioner is coming to the meetings, that's been
17 very refreshing and I feel like these TACs are going
18 to be very helpful for us in the future. Thank you.
19 DR. PARTIN: Very good. Thank
20 you. The Nursing TAC did not meet. Optometry.
21 DR. COMPTON: Steve Compton.
22 We did not meet either and we meet again in April.
23 DR. PARTIN: Thank you.
24 Pharmacy.
25 MS. HUGHES: I got a notice

1 this morning from Suzi Francis, the Chair. They're
2 having some new computers installed or something
3 today. They did meet but there were no
4 recommendations.
5 DR. PARTIN: Thank you,
6 Sharley. Physician Services.
7 DR. McINTYRE: Hi. I'm Dr.
8 William McIntyre, Vice-Chairman of the Physician TAC.
9 We met March 15th. We had a
10 quorum. We discussed provider enrollment,
11 telehealth, public health trends, and we had a
12 recommendation regarding modifiers for telehealth.
13 There are two modifiers we are
14 recommending - acute versus chronic care so that
15 those modifiers could be used by the Department and
16 by the MCOs to track reimbursement and to track
17 trends basically to help with reimbursement and also
18 modifiers to show whether a provider was present with
19 the patient when the telehealth visit was done or no
20 provider.
21 For example, at some visits,
22 you will have a nurse practitioner with the patient
23 and the physician at some distance away and the nurse
24 practitioner could help with abdominal outpatient,
25 examination of throat, ears and so on.

1 The last thing we discussed was
2 the reimbursement rate from the MCOs and from the
3 Department for telehealth visits. There's a proposal
4 up in the air to reimburse those at 85% of what an
5 office visit would be reimbursed for.
6 And it's our position that
7 that's probably not going to be enough reimbursement
8 to attract physicians to have the providers to invest
9 in the technology necessary to do telehealth.
10 That's everything that we had.
11 Does anyone have any questions?
12 DR. PARTIN: Any questions?
13 Thank you. Podiatry. Primary Care.
14 MS. HUGHES: Primary Care did
15 not meet.
16 DR. PARTIN: Right. Therapy
17 Services.
18 DR. ENNIS: Good morning. I'm
19 Beth Ennis. I currently serve as the Chair of the
20 Therapy TAC.
21 We wanted to thank the MAC for
22 their assistance in these new task force
23 recommendations. We realize that this came out of a
24 meeting of ours being cancelled, and I apologize for
25 creating chaos but we felt pretty strongly about it.

1 DR. PARTIN: It wasn't just
2 that.
3 DR. ENNIS: We did meet on the
4 12th. Depending on which rule you use, we may or may
5 not have had a quorum. We're going with no because
6 we don't have the ruling yet on video conference but
7 we had been told previously we could. So, we had
8 three in the room and one on video out of our six.
9 No major recommendations coming
10 out because we didn't have the quorum that we could
11 call but we did discuss several things. We're still
12 having issues every January with codes being loaded
13 incorrectly.
14 We do appreciate DMS' work and
15 a lot of the things that we had requested be updated
16 were updated and we know that took a lot of work, but
17 there are still some codes that have been on there
18 since we were added five years ago that every time
19 they get reloaded in January, they're reloaded as
20 visit codes instead of timed codes.
21 We're still trying to work on
22 processes to fix that because the MCOs go by that fee
23 schedule, and, so, it impacts everybody's
24 reimbursement for a good four months until we can get
25 it fixed.

1 We are working with MCOs on
2 different issues and appreciate the ability of the
3 TAC to do that.
4 We also discussed telehealth
5 and are concerned about the 85% reimbursement after
6 Year Two. I believe that the statute that was passed
7 said that it would be parity. So, we're looking into
8 what that means.
9 We did get word from DMS that
10 they were going to remove the differential for the
11 Clinical Fellow for speech and that they would be
12 billing under their senior therapist number.
13 We have asked for the same
14 thing for PT assistants and OT assistants, and at
15 this point, they've said no. So, we're going to
16 continue to dive into that because that's going to
17 impact access in providers pretty tremendously but
18 that's all we have. Thank you.
19 DR. PARTIN: Thank you, and
20 that's it for the TAC meetings.
21 I'd like to go back for a
22 minute to the recommendations from the workgroup.
23 The TAC Chairs will need to let Sharley know where
24 your meetings are going to be held so that she can
25 post that appropriately. I'm sure that there will be

1 other discussion as we move forward on this but that
2 is just something that came to mind just now as far
3 as public notice for those meetings.
4 MR. CARLE: Stephanie, given
5 what we submitted, obviously the Department hasn't
6 had a chance to review that; but I guess what we
7 would ask for is that the review and communication of
8 any concerns that would be had on the side of DMS,
9 that's discussed maybe with the Executive Committee
10 representing the workgroup and we do that much prior
11 to our next meeting, if possible.
12 MS. BATES: Right.
13 MR. CARLE: I know that
14 certainly with everything that's going on with the
15 waiver and everything, we certainly understand.
16 MS. BATES: Right. This was
17 the first I saw these recommendations this morning.
18 And actually I was in the Secretary's office
19 obviously earlier this morning, and, so, we talked
20 about how we need to get together and discuss these.
21 So, absolutely.
22 DR. PARTIN: Thank you. So,
23 moving to New Business, we would like to schedule
24 reports from the MCOs as we have done in the past so
25 that we can get an update on where the MCOs are with

1 everything. We've done this before, so, it's not
2 anything new but we'll need to get that scheduled
3 where we have a couple of them report at each
4 meeting.
5 MS. HUGHES: Do you want two?
6 I was going to ask, did you want a couple to report?
7 DR. PARTIN: I think so.
8 MS. HUGHES: That way, we can
9 get them all in during the year.
10 DR. PARTIN: Yes.
11 MS. HUGHES: About twenty to
12 twenty-five minutes?
13 DR. PARTIN: Twenty minutes
14 each.
15 MS. BATES: So, do you want to
16 schedule certain topics for them to go over?
17 MR. CARLE: Well, it would be
18 similar to what we have done before. I asked for
19 this to be put back on the agenda, looking at the
20 quality outcomes, access metrics which they already
21 post, ED utilization. I'd like to see the cost per
22 member per month.
23 Obviously they need to report
24 their financials which would include their margins
25 and any new programs innovative that they might have

1 that differentiates them from somebody else.
2 So, Stephanie, while you came
3 back up, I've got a question. Does DMS go back and
4 audit the RFP that they originally sent to these
5 individuals that have been selected, not the new
6 process, but the old process that selected the five
7 and do you audit if they are in compliance with what
8 was actually in the RFP?
9 MS. BATES: Not necessarily the
10 original RFP. We just go by the current contract.
11 MR. CARLE: But you do have an
12 active audit system that audits how they are
13 complying with the contract.
14 MS. BATES: We have a whole
15 team that's dedicated to that contract and we're
16 looking at that. As a matter of fact, I'll just go
17 ahead and let you know that we're kind of looking at
18 how that is set up and how we want to do it
19 differently when we implement the new contracts under
20 the RFP that will be awarded in 2020 because we feel
21 like we could be a little bit more efficient.
22 Obviously, in state government,
23 we fall into the same old thing and, so, we don't
24 want to do that. We want to reevaluate how it's set
25 up.

1 MR. CARLE: Good, because my
2 next question was going to be, is that within the
3 Department of DMS or is it in an audit function in,
4 let's say, Accounting or someplace else?
5 MS. BATES: No. Right now it's
6 mainly within DMS. Where the new RFP will include a
7 lot more strength in the foster care, we're going to
8 have more of an audit capability for DCBS to audit
9 their part of the contracts. So, that's just part of
10 the whole foster care transformation.
11 That's kind of what we're
12 evaluating right now is how the managed care
13 oversight is set up and if we do need to bring in
14 outside entities to do that.
15 MR. CARLE: Okay. That's
16 right where I was going.
17 MS. BATES: We are definitely
18 looking at that and we know that we are just short on
19 staff really. The bandwidth is just not there.
20 MR. CARLE: Okay. Thank you.
21 MS. STEWART: Stephanie, I have
22 a question related to that. Is there opportunity for
23 you to do a patient satisfaction survey type thing
24 with providers on how we feel like the MCOs are
25 doing?

1 MS. ALDRIDGE: Which we've
2 asked that before.
3 MS. BATES: And I believe that
4 we have something like that. Let me look and see
5 what all the satisfaction surveys that we have going
6 on right now. There are so many things you wouldn't
7 believe, like, how many that go on behind the scenes
8 that you might not know about.
9 I'll get a list of the surveys
10 that the MCOs are required to do now. I know we from
11 Medicaid don't necessarily send something directly
12 out but that's a good idea.
13 MS. ALDRIDGE: And, Stephanie,
14 yesterday I got an email from some of our DME
15 providers. They're starting to get emails from a
16 Molina.
17 MS. BATES: Okay.
18 MS. ALDRIDGE: And they've
19 never heard of them before. And when they pull it
20 up, it's a new MCO for Medicaid out of Louisville.
21 So, is this the new MCO?
22 MS. BATES: No. We are not
23 contracted with Molina.
24 MS. ALDRIDGE: And you're not
25 going to?

1 MS. BATES: I can't comment on
2 that. I have no idea if they would bid. They are
3 not a current MCO now.
4 MS. ALDRIDGE: Well, I know
5 they are not current but it's been discussed, I
6 think, when it was Commissioner Miller before that
7 you all were not going to expand more MCOs in the
8 state. So, is that still the way it is? You're
9 going to try to keep it to a minimum?
10 MS. BATES: So, we're still in
11 the middle of the procurement process and I really
12 can't comment. And we're actually in a blackout
13 period to where we're not talking to anybody at this
14 point.
15 MR. CARLE: Teresa, I think
16 that Molina is interested in applying through the
17 process to become a provider in the State of
18 Kentucky.
19 MS. ALDRIDGE: Well, they sent
20 information out but they didn't send any--what I'm
21 hearing, they're not sending out any like fee
22 schedules or anything.
23 DR. PARTIN: United Healthcare
24 is also sending out emails.
25 DR. GUPTA: Stephanie, could

1 you also ask the MCOs to present their translation
2 services?
3 MS. BATES: Sure. What I will
4 do with that is I will go ahead and outreach them and
5 kind of get an update on where they are on those and
6 kind of send it to you all, but, yes, we will let
7 them elaborate.
8 MR. CARLE: But we would like
9 also, as was brought up, the patient satisfaction
10 surveys directly from the patients, not necessarily
11 from the providers but the patients as well, but I
12 think the providers is a great idea.
13 DR. PARTIN: And, then, one
14 other thing I would like to add is for them to report
15 on their provider access, the primary care and the
16 specialties.
17 So, Sharley, would you contact
18 the MCOs and start to get that going?
19 MS. HUGHES: Yes.
20 DR. PARTIN: Okay. Great.
21 Thank you.
22 MR. CARLE: I think last time
23 we went alphabetically. I think we started with "A",
24 so, we can start from the back and come forward this
25 time.

1 MS. HUGHES: If you want to do
2 that, we can.
3 MR. CARLE: It makes it easy.
4 DR. PARTIN: Anything else on
5 that? Thank you.
6 Then, moving on to the next
7 item of New Business, we have talked in the past
8 about responses to TAC recommendations that were not
9 very helpful, and the Commissioner asked me at the
10 last meeting to bring forward some examples of that.
11 So, what I did is I asked some
12 of the TACs for some help and, then, I also went
13 through some of the recommendations, the responses to
14 the recommendations from the TACs.
15 And, so, I've got some examples
16 of things. And this isn't meant to be critical. I
17 want to do this in a way that is constructive so that
18 it can be more helpful when we're getting the
19 responses back.
20 So, back in March, this was to
21 the Consumer Rights and Client Needs TAC. There was
22 a recommendation that the medically frail screening
23 questions be asked of the Medicaid applicants and
24 enrollees on the Benefind system or paper
25 application.

1 And the response was: DMS is
2 currently in the process of making changes to the
3 Benefind system and that was sort of like a non-
4 answer. It didn't really respond to the
5 recommendation.
6 Another example from that same
7 report was to streamline the grievance and appeals
8 process of the 1915(c) waivers and 1115 waiver.
9 And, then, it says: Redesign
10 efforts will review the grievance and appeals process
11 within the rules and regulations mandated by CMS.
12 Certainly, we would expect DMS to review things as
13 CMS requires but that really didn't answer our speak
14 to the recommendation.
15 Another example - this is from
16 a Behavioral Health TAC meeting - the recommendation
17 was that DMS commit to creating a stakeholder
18 advisory council.
19 And the response was: The
20 Department will follow federal regulations regarding
21 advisory councils. Again, that didn't really speak
22 to the recommendation. It just wasn't an answer, I
23 don't think.
24 Another example, DMS to pay the
25 cost of background checks for persons hired to

1 deliver participant-directed services in the Home-
2 and Community-Based waiver and not have the Medicaid
3 waiver recipient pay.
4 And, then, the response is:
5 Preemployment requirements will be reviewed during
6 the 1915(c) HCBS waiver redesign which didn't speak
7 to the recommendation at all.
8 I have more examples if you
9 want.
10 MS. BATES: I think you've made
11 yourself clear.
12 DR. PARTIN: Okay, but I think
13 it's important for all of us. In order for the MAC
14 to be advisory to DMS and for the TACs to bring the
15 issues forward that the responses to the
16 recommendations be more clear and more constructive
17 so that they be more helpful.
18 MS. BATES: Sure. Thank you.
19 DR. PARTIN: Thank you. Does
20 anybody have anything else they would like to add?
21 If nobody has any other
22 business, I think this might be the fastest meeting
23 in the history of the MAC.
24 MS. BATES: You're welcome.
25 DR. PARTIN: So, any other

1 business? No.

2 Would somebody like to make a

3 motion to adjourn?

4 MS. ALDRIDGE: I make a motion.

5 MR. TRUMBO: Second.

6 DR. PARTIN: Teresa motions.

7 Jay seconded. All in favor. Opposed. So moved.

8 Thank you all.

9 MEETING ADJOURNED

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