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
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DR. PARTIN: Good morning. We’ll go ahead and get started. Everybody, if you would please remember to turn on your microphone when you speak so that our transcriptionist can hear what you say.

The first item on the agenda is approval of minutes from the November meeting.

MS. HUGHES: Beth, I think that’s actually supposed to be January. I just realized that.

DR. PARTIN: Okay. I just assume that you’re right, Sharley.

MS. HUGHES: Sorry about that.

DR. PARTIN: So, I stand corrected.

MR. CARLE: I make a motion that we approve the January meeting minutes.

MR. TRUMBO: Second.

DR. PARTIN: Any discussion? All in favor, say aye. Opposed? So moved. We’ll move on to Old Business.

First on the agenda is the memo sent from the Commissioner back in January regarding the TAC meetings and how those meetings will function.

And as a result of that memo, a
workgroup was formed consisting of some members of
the MAC and all of the TAC Chairs.

So, I’m going to assume that
all of the TAC members here and all of the MAC
members here are aware of the items that was in the
Commissioner’s memo. Is that correct? Okay. So, we
don’t have to go over that.

The workgroup did come up with
some recommendations and I will read those so that we
have those in the transcription of the meeting.

The Medicaid Commissioner sent
a directive to the Medicaid Advisory Council (the
MAC) and the Technical Advisory Committees (the TACs)
regarding how she believes the TACs should conduct
their meetings and where the meetings shall be held.

A workgroup consisting of some
members of the MAC and the TAC Chairs was formed to
address the Commissioner’s directive.

KRS 205.540(4) states that the
MAC shall adopt rules governing its procedures. This
statute clearly grants authority to the MAC to set
its own rules.

There’s no reference in the
statutes for the MAC or the TACs that would give the
Commissioner authority over them either to cancel
their meetings or to dictate their agenda or to try and micromanage their operation.

Therefore, scheduling of meetings, the MAC bylaws stipulate that the TACs may schedule meetings with thirty days' notice and that the TACs do not need to schedule a year's worth of meetings. The open meetings' statute requires a two-week notice.

Issues may arise and a TAC may want to schedule a meeting to discuss the issue. However, if a TAC chooses, they may schedule their meetings for a full year.

Agenda. The MAC bylaws do not require the TACs to provide the agendas two weeks prior to the TAC meeting. The MAC is required one week in advance, according to the bylaws, and the MAC Chair is supposed to provide an agenda two weeks prior to the MAC meeting.

Cancellation of meetings. The MAC bylaws do not allow for DMS to cancel a TAC meeting or a MAC meeting due to the agenda not being provided.

TAC meeting minutes. For the past year, DMS has paid a court reporter to be present at TAC meetings. This produces a long
verbatim report of the meeting which can run as long as a hundred and fifty pages. This seems a waste of money. The TACs are capable of taking their own minutes and should do so. This would save DMS money which could be used in more productive ways. The TAC meeting minutes may be provided to the MAC as well as any recommendations.

TAC recommendations. TACs may provide some background information to the MAC in addition to recommendations. The background information is sometimes helpful to the MAC and to members of the public who are in attendance at the MAC meeting.

If time is running short at a MAC meeting, the MAC Chair may request that TACs present only their recommendations so that the TACs may have time to give their reports.

Topics for TAC meetings. The TACs should be able to discuss anything a TAC member wants to bring forward at their meeting. While individuals may be the only one with reimbursement or other issues, by bringing it up at a TAC meeting, a broader issue may be identified. Other members of the TAC may be having the same issue.

Likewise, TAC members should be
abler to discuss at their meeting any problems they are having with an MCO. MCOs are invited to TAC meetings and issues may be remedied at that point rather than having to bring the issue to the MAC.

Location of TAC meetings. TACs should be able to meet in the Capitol Annex or any other public location that is easily accessible to the public and TAC members. Parking is convenient at the Annex and rooms easily accessible. The location proposed by the Commissioner is not easily accessed and parking is difficult.

Attendance at TAC meetings by DMS staff. While DMS staff is certainly welcome to attend any of the TAC meetings and most TACs find it helpful to have DMS staff present, they should not be required to attend.

And that is the complete report from the workgroup. So, having read that into the record, I would like to ask if any MAC members have any comments that they would like to make?

DR. ROBERTS: I was not part of this task force, but one of the guidelines that was kind of set forth by the Commissioner was that this forum was a platform for advising Medicaid on policy issues.
When we look at barriers to care and quality of care delivered to the Medicaid recipients, one of the common things we find are either for physicians that don’t participate in Medicaid or limit the number of Medicaid recipients that they will take.

At least from my discussion with some other practices and providers, there are a couple of things. One is reimbursement issues or the amount of reimbursement. Obviously, DMS has a limited budget. I’d love for you guys to have an infinite budget and that would solve a lot of problems.

Number two are the number of PA’s involved, and number three are the denials.

So, when you talk about policy decisions, improving the quality and access of health care to these recipients, that goes hand in glove with fixing the reimbursement and the billing and the denial issues. So, I think it’s very difficult to separate those two.

Now, I agree. The entirety of every MAC meeting and every TAC meeting should not all be about why didn’t I get paid for this wound debridement in November of last year; but when it
impacts the delivery of care to such an extent, you have to have some reimbursement, some improvement in the billing, coding, reimbursement and review process as part of the discussion of public policy.

The other comment that I would make — and this has been, unfortunately, an escalating tone in the recent MAC meetings — I’m one of the younger ones, I think, on the MAC — but I’ve sat on a number of hospital state and national committees.

When you bring different stakeholders, different specialists, lay people all together in the same room, Napoleon Hill talks about a definitiveness of purpose and building your mastermind alliance, and that’s exactly what the mandate of this Board is.

When you bring all these people, when you put them around a table, all the credentials, all the echos go out the window. When you’re working hard to fix a specific problem, then, the authority doesn’t really matter so much.

If we define exactly what this Board is set out to do, then, that solves a lot of the problems we’re talking about.

DR. PARTIN: Thank you, Dr.
Roberts. I think those points are well-taken. Any other comments?

So, moving forward, we need to make a decision as far as the function of the TACs and how the TACs will conduct their meetings.

And, so, is this Council in agreement with the recommendations from the workgroup?

MS. CURRANS: Do you need a motion to accept the recommendations of the workgroup?

DR. PARTIN: Yes, please.

MS. CURRANS: I’ll make that motion.

MS. ALDRIDGE: Second.

DR. PARTIN: Any further discussion? All in favor, say aye. Any opposed? So moved.

So, moving forward, the recommendations from the workgroup will be implemented as far as the functioning of the TAC meetings.

Next on the agenda is an update on the Opinion from the Attorney General regarding video teleconferencing.

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So, just to give you a little bit of an update, our Secretary, Teresa Aldridge, wrote a letter to the Attorney General requesting an Opinion on behalf of the Council, and the Attorney General’s Office responded saying that we had to have a letter coming from the Chair of the Council rather than the Secretary requesting that Opinion. So, I did write a letter and submitted it to the Attorney General. And I checked the status of that yesterday and the Attorney General’s Office said that an Opinion was still pending and that I should check back in about two weeks. So, hopefully we’ll have an Opinion by our next meeting.

Next on the agenda, updates from the Commissioner.

MS. BATES: Good morning. So, obviously, I’m not Commissioner.

DR. PARTIN: Good morning.

MS. BATES: Stephanie Bates, Deputy Commissioner of Medicaid.

So, just very quickly, I’m just going to give a quick 1115 Waiver update. I’m sure none of you heard but we did get a decision late last night, so, it was a long night which is part of the
reason why the Commissioner is not here.

And just to kind of update, there’s I think a call going on with DOJ right now.
So, we’re kind of evaluating the situation.

The good news is that we got this decision two days earlier than the last time and we had a bunch of contingency plans in place. So, we were able to just kind of stop systems for right now and we’re meeting all day today to decide what to do going forward as far as the systems but nothing is going to change. Everything is on hold.

So, do you all have any questions about the waiver? Okay. Good.

Then, I’m going to let Jonathan do a legislative update.

MR. SCOTT: Good morning. I’m Jonathan Scott. I’m the Regulatory and Legislative Advisor for DMS. I’m here to talk to you about some of the legislation that was passed.

Do you all have any questions about any legislation before we get started? I have quite a few notes. It’s whatever is easier for you.

DR. PARTIN: Unless anybody has any specific questions, I think it would just be easier for you to go through your list.
Mr. Scott: Sure. Okay.

Senate Joint Resolution 7 is a diabetes prevention study. It’s going to require DMS to study the potential impacts of implementing programs similar to the KEHP Diabetes Value Benefit Plan or the Diabetes Prevention Program.

We’re going to look at the estimated cost of the program, the health benefit that this program could give Medicaid beneficiaries, and any potential financial savings.

The report needs to be submitted by November 1st of this year. We will work with our MCOs and DMS staff, possibly a couple of other entities to study the impacts of implementing this and we’ll submit a report by November 1st to Health and Welfare.

Mr. Carle: Jonathan, do you have a little bit more detail, though? When you say implementing this, is it a study on Alc? It just says diabetic-related. We need a little bit more detail.

Mr. Scott: It’s just a study of the Diabetes Prevention Program.

Mr. Carle: So, Stephanie, do you know any of the program scope or anything?
MS. BATES: Basically, we’ve been asked for several years to cover the Diabetes Prevention Program. I don’t remember how long the program is but it’s ongoing. Like, it goes over the course of several weeks and it is diabetes education; but to get into the program, you can’t already be diabetic. It’s kind of like you’re in a pre-diabetic state.

So, one of the reasons why we haven’t just covered it is because, with Medicaid, we have to figure out, just because of the federal rules, which provider type that we have can provide it as far as licensure and all of that and, then, the medical necessity piece because with the person who seeks out the program is not diabetic, so, doesn’t have that diagnosis, we’re trying to figure out how to cover it.

Other states do it. So, that’s part of what the study will be is we’ll look at other states. We already have an MCO, I think - and don’t ask me who - that’s doing a pilot.

So, I think that’s what the legislation was meant to do was to look at all of that, see if it will save us money to prevent diabetes which it sounds like it would.
Mr. Carle: Okay. Thank you.

Mr. Scott: Senate Bill 30 requires coverage of genetic tests for cancer risk if it’s consistent with the National Comprehensive Cancer Network. It also lowers the age for colorectal cancer examinations and first screenings to 45 from 50.

That has been signed by the Governor. And going forward, we’re going to coordinate with the MCOs to determine the extent to which they will be impacted and coordinate with the Department of Insurance as necessary.

Dr. Partin: So, what type of genetic testing are we talking about?

Ms. Bates: It was very general. The bill was very general, so, that’s where we are is to figure out what the recommendations of—what was the—

Mr. Scott: The National Comprehensive Cancer Network.

Ms. Bates: So, we have to evaluate what their recommendations are going forward and kind of put that with testing.

Dr. Partin: Would this be just voluntary on the part of the patients if they wanted
the testing done? DMS would cover it?

    MS. BATES: Yes. It would have
to be ordered by a Medicaid provider but that’s
between obviously the patient and the provider.

    DR. PARTIN: Right. Okay.
    MR. CARLE: But they would
actually cover the cost of the genetic testing.

    MS. BATES: Right. And, of
course, it’s not going to be all----
    MR. CARLE: It will be marker
specific, yes.

    MS. BATES: It’s not going to
be the whole plethora of genetic testing.

    MR. CARLE: Specific to cancer.
    MS. BATES: Yes.
    MR. CARLE: Great.
    MR. SCOTT: Senate Bill 54
requires insurers to develop processes for electronic
prior authorizations. There’s limited circumstances
where a prior authorization could continue for a
year. We’re not sure that that’s going to be a big
impact to the Medicaid population.

    MS. CURRANS: Can you repeat
what you just said? I can’t hear you.

    MR. SCOTT: I don’t know what I
just said. We’re going to develop process--the bill requires insurers to develop processes for electronic prior authorizations. Then, there’s limited circumstances where a prior authorization can continue for a year.

I’m not totally sure the extent to which DMS or the MCOs will be impacted by this because of some House amendments that were made to that bill.

So, going forward, we’ll ensure that an electronic prior authorization process is implemented within the Department and the MCOs. We may amend the regulations but these are DOI statutes that we’re dealing with here, and the bill will be effective at the end of June.

MS. CURRANS: Is this the bill that will keep the MCOs from denying the device separate from the procedure?

MS. BATES: No. The takeaway from this bill for us, it sounds like, is that MCOs will be required to allow providers to electronically request a PA.

MS. CURRANS: Right. And, so, what is this bill number?

MR. SCOTT: Fifty-four.
MS. CURRANS: House Bill 54?
MR. SCOTT: Senate Bill 54.
MS. CURRANS: Senate Bill 54.

Was that Alvarado’s bill?

MR. SCOTT: Yes.
DR. PARTIN: My understanding of the bill also is that if something is preauthorized, then, it is continued to be authorized for a year rather than right now what happens is that something can be preauthorized and, then, three months later, it’s not.

MR. SCOTT: That became more complex with Senate and House amendments to the bill. You will want to check the House Committee substitute on that.

DR. PARTIN: Okay.

MS. CURRANS: So, can you help me because I believe our Association relayed to us because we had had multiple issues with maybe a procedure doesn’t even need a PA but a type of device used within that procedure supposedly did and, so, they could deny the whole procedure because you didn’t prior auth the screw.

Now, that was supposed to--I thought that was in 54.
MR. SCOTT: I don’t recall seeing that in 54 but we can review it again.

MS. CURRANS: Okay. Thank you.

DR. PARTIN: You can go ahead.

MR. SCOTT: House Bill 224 which the final version of that bill, we have come to understand the problems impacting the DME provider community.

In particular, the 21st Century Cures Act has acted as a serious stressor for many of these providers. So, the bill was limited to a specific group of DME codes and services that were impacted by the 21st Century Cures Act.

The final version also removes some language about medical necessity and a requirement to purchase medical necessity criteria for DME providers.

So, the final version is reimbursement at 90% of the DME fee schedule for about 250 HCPCS codes and it includes certain requirements for manually-priced items that copy current regulatory language and it has reimbursements only provided to in-network providers and it will also be effective at the end of June.

Senate Bill 110, this ended up
being a clean-up of last year’s House Bill 69 for us. In our analysis of that original bill, we had concerns about the ability to quickly or immediately enroll providers for events such as out-of-state transplants.

The current statute didn’t allow for delays, for enrollment delays caused by external entities such as FBI fingerprint background checks, searches of federal databases and things like that.

It also didn’t emphasize the differences between enrollment and credentialing in Kentucky. So, the bill will also allow the KHA to expand more expansive credentialing activities.

So, going forward on this one, we will be able to retain a federal match to build and operate the Partner Portal. We will continue to implement the Partner Portal Program with the changes from Senate Bill 110 and it will take effect at the end of June.

DR. PARTIN: Okay.

MR. SCOTT: House Bill 320, this bill establishes a Hospital Rate Improvement Program. So, the hospitals will pay an assessment to the fund that will be used as state matching dollars
to draw down federal Medicaid funds.

The rate improvement will function to increase Medicaid reimbursement for inpatient hospital services provided to Medicaid recipients. There’s formulas and processes to be followed by DMS and participating hospitals in the language.

Going forward, we’re going to prepare a State Plan Amendment to request federal approval and federal financial participation for the new Rate Improvement Program.

We will promulgate administrative regulations to implement this assessment as we go forward and it will be effective at the end of June.

DR. PARTIN: Does this affect all hospitals including critical access?

MR. SCOTT: Yes, all but universities.

MS. CURRANS: I think it’s any Medicaid inpatient claim.

MR. SCOTT: Then, Senate Bill 149 will allow a provider to appeal multiple claims in a single external, independent third-party review. It will also allow for a single administrative
hearing for an appeal of the final decision of an external review that involves multiple claims.

We have experienced a market increase in expenditures in this program over the previous year. So, we are going to continue to review and report on the--going forward, we’re going to continue monitoring these increased expenditures.

We’re going to conduct a review of our statutes and administrative regulations relating to this program to see what improvements can be made.

We will coordinate with our Administrative Hearings Branch at the CHFS to determine the extent to which the administrative hearings can be consolidated. We will promulgate administrative regulations to implement this legislation and any streamlining of processes needed and it will be effective at the end of June.

And that’s all I’ve got. If you all have other legislation you wanted to ask about or if I could clarify anything.

DR. PARTIN: Anybody? Thank you.

MS. BATES: Now I’m going to ask Pam Smith to come up and give a 1915(c) Waiver
update.

MS. SMITH: I am Pam Smith. I am the Division Director for the Division of Community Alternatives.

Most notably, we released the waiver applications for public comment beginning on March 15th. That period is going to run through April 15th.

We will consider all of the public comments that were submitted from January 7th which was the original start of public comments all the way through April 15th. Those will be summarized and responded to.

Just to highlight the most important changes we made while we paused public comments, probably the most notable is the change to how patient liability will be calculated.

So, instead of it being 100%, it will be up to 300% which will change most of the waiver patients to not have a patient liability. I think we’re going to have less than twenty people that will be left with a patient liability with that calculation change.

We also responded to a change that CMS issued in January around participant
satisfaction surveys. So, that was added.

Our rate study is coming to a close today. In January, we had fifteen providers take a pilot survey and then we used that survey to form the final survey. That was released on February 25th to all waiver providers and it all must be submitted by tomorrow. And so far, we’ve had a pretty good turnout of responses from all of the waiver groups.

DR. PARTIN: Any questions?

Thank you.

MS. BATES: And that is our update. So, do you all have any questions for me?

DR. PARTIN: Stephanie, when do you think we will be hearing more about what’s going to happen with the 1115 Waiver?

MS. BATES: So, like I said, we’re meeting today. We’re going to go over just what the actual judgments were. Obviously, the Judge handed down a decision on Arkansas, too.

So, we’re kind of just trying to look at everything, but as soon as we know, the Kentucky HEALTH website, it’s new. This morning, there’s a new Kentucky HEALTH website just so you know that looks different. And, so, the updates as
we get them will be on there, and we’ll let you know. Obviously, I will communicate to Sharley and communicate out to the TACs and the MAC.

DR. PARTIN: Is there any possibility that maybe the Council could be informed about things a little bit ahead of time instead of just hearing it in the newspaper?

MS. BATES: Sure, but trust me, you found out when we found out last night.

DR. PARTIN: Sure, as far as the Judge, sure, but as far as what DMS is going to do?

MS. BATES: But, yes, absolutely.

DR. PARTIN: Thank you.

MS. BATES: Any other questions? Okay. Thank you.

DR. PARTIN: Then, we will move on, then, to reports and recommendations from the TACs, and first up today is Behavioral Health.

DR. SCHUSTER: Good morning. I’m Dr. Sheila Schuster, Chair of the Behavioral Health TAC.

We met for the first time at the CHR Building as directed by the Commissioner; and
for the first time since we were constituted, we did not have a quorum and part of that was that we had one of our TAC members who had to stay here in the Annex to monitor legislation, and if we had been able to meet in the Annex could have attended our meeting.

And also in attendance were representatives from DMS, from all five Medicaid MCOs and members of the behavioral health community.

Pam Smith gave us an update in response to a recommendation made at the last MAC meeting regarding reassessments that overlap or coincide with the waiver renewal date and we were very pleased that DMS responded. That’s probably the most response that we’ve ever had from DMS to look at that issue and to give us some feedback and to tell us that they will continue to look at it.

What happens is that if a person is hospitalized or in an institution and their renewal date on their waiver comes up while they’re in there, they stand to lose their waiver slot.

And these waivers, as you all know, have long waiting lists, so, it’s a real issue, and they have been very helpful in letting us know that there is a sixty-day extension that can be done in some of the waivers. And I think one of the
things that is happening in the redesign is that they want to make that consistent across all the waivers. So, it would be very helpful for our folks because it’s just bad luck, if you will, that they happen to be hospitalized or in an institution at the time of their renewal. So, we did appreciate that.

We were given a brief update on the 1115 waiver by Sharley Hughes, and, of course, it was at that time to go live on April 1st.

The agenda also had an item about the recent DMS change in reimbursement and the time requirement for therapeutic rehabilitation services.

For those of you who are not familiar, TR or day treatment programs are really the mainstay for the treatment that we can offer for people with what we call SMI, severe mental illness.

And without any notification or process, we found out in early February that DMS had decided to not only lower the rate for that service but also put a time frame on that it had to be at least five hours a day and most of the TR programs don’t have people come. Many of our people cannot participate for five hours a day. It’s just too much for them.
It was going to put our TR’s out of business, quite frankly. And an agency like Bridgehaven Mental Health Services which has saved the State millions in hospital costs by keeping people out of the hospital were going to have to close.

So, there was good news. Because of the outcry, if you will, from the agencies that run those programs, DMS stepped back and didn’t change the rate but at least changed the time requirement and set a rate for under five hours which makes it doable.

I pointed out to them that we have lots of expertise at the TAC not only in the TAC members but also in our numerous people that come from the behavioral health community, and this is exactly the way that a TAC, I think, should be used because obviously this recommendation didn’t just fall out of the sky.

DMS had to be thinking about it at least the last couple of months of 2018. And if they had come to us with here’s our problem or here’s what we’re thinking about, we could have had a dialogue about that and saved this upset that went on for six weeks, two months and now is going to have to
be changed because the MCOs thought they were having to change that billing.

And, so, the whole thing is just a mess and I really think we could have avoided some of that. We might not have convinced them not to make the changes but the changes would not have been harmful and we could have explained why it was so important not to have a five-hour time requirement which didn’t make any sense clinically for the people that we were trying to serve, so, again, that kind of use of the TACs.

We continue to have questions about the medically frail designation. There was some miscommunication about when people were going to be notified whether they had that designation or not.

And as I’ve pointed out to you all before, our clinicians are taking up their time to do these attestations and then they get no feedback about whether the attestation has been received or is in process or has been approved or has been sent on for further whatever. It just continues to be a real problem.

The new policy for universal copays which we’ve expressed our concern about has been in effect for two months, and we are looking at
doing a more systematic data-gathering and we will have that report at our next TAC meeting and we also had some input from the brain injury community.

Our next meeting is on May 14th, and I’m giving you public notice that we will be meeting in the Capitol Annex.

I do want to make a point that was not in the recommendations, Madam Chair, and that is that we sent our dates for the year to DMS and the location was listed as the Capitol Annex.

And when I indicated to Sharley that we wanted to have our March meeting in the Capitol Annex, she said, no, you can’t because the public notice says you’re going to meet at the CHR Building and I said that was not my public notice. The notice I sent you was that we were going to meet in the Annex.

So, the other thing that’s being changed by DMS are the notifications that the TACs are sending not only about the dates but about the locations.

So, I’m going to take this as an opportunity to make a public notice that we will be meeting in the Capitol Annex on May 14th at 1:00 p.m.
MS. HUGHES: Dr. Schuster, just as a clarification, the website is the public notice of the meetings. So, I know you send an email out to your people that usually come to your meetings but that’s not what constitutes the public notice for the meeting. It’s what is put out on the website for the whole world to see. That’s what constitutes as the public notice.

DR. SCHUSTER: I understand that. I understand that, Sharley, but somebody at DMS changed the notice that we had sent because if you look at what we sent you, and we’ve had it on our TAC reports, every TAC meeting is listed as being in the Capitol Annex. So, it was changed. That’s my point.

So, I’m telling you we’re going to meet in the Capitol Annex and I’m giving notice in any way I can and I will send it to you in writing but that’s what should be posted on the website. I have no control over what gets posted on the DMS website.

MS. CARLE: So, Stephanie. Dr. Schuster, you can’t see what she is saying behind you.

MS. BATES: I’m saying got it.
DR. SCHUSTER: Got it. Thank you very much.

MR. CARLE: So, you got it taken care of?

MS. BATES: Got it.

MR. CARLE: Thank you.

DR. SCHUSTER: I appreciate it. My other question is can we all have copies of the recommendations that you gave in the TAC report? Will that we circulated by Sharley to the TAC Chairs?

DR. PARTIN: Certainly, yes.

DR. SCHUSTER: Thank you very much. We appreciate that committee work. Thank you.

DR. PARTIN: Next up, Children’s Health.

MS. KALRA: Hello. I am Mahak Kalra, Co-Chair of the Children’s Health Technical Advisory Committee.

Our TAC met on Wednesday, March 13th. We did have a quorum. This is a huge deal for us because often at times we don’t. So, we’re excited that we do have recommendations today. The Children’s Health TAC has been discussing or reviewing issues around psychotropic medications among children. For those
of you who are not familiar with psychotropic medications, these are medications that could affect mind, emotions and behavior. Typical examples of these are antipsychotics, antidepressants, anxiety medications, stimulants and mood stabilizers as well.

In Kentucky, Dr. Lohr’s presentation with the DCBS has shared that we are over-prescribing for children, especially those in the foster care system. And, so, we were very concerned when we were hearing this data and when we were having this discussion.

And in a way to support Medicaid and Dr. Lohr’s efforts towards de-prescribing, we would like to propose developing a best-practice guideline or improve interventions to serve not only as guidelines but just to deter folks from prescribing psychotropic meds as the first-line of defense, and, like I said, first-line of defense.

We understand there might be issues where this might be necessary later down the road, but often at times, this is the only thing being prescribed to these young children and we know that there are some impacts to their development at that time as well.

So, we would like to propose
the following recommendations: To ensure that
prescribing psychotropic medications are a part of a
multi-modal treatment plan when providing supports
for these children. Again, we think that if you are
going to prescribe something along those lines,
couple it with therapy or other types of
interventions that are best practice-based.
Also ensure that Medicaid
reimburses for children to have access to these other
therapies as well. So, an example, applied behavior
analysis, that’s something that could be used for
children with the autism spectrum disorder and other
disabilities, as well as occupational therapy to
improve emotional and behavior regulation.
So, those are some of our
recommendations. I apologize that you don’t have it
in front of you but Sharley does have a copy and she
is happy to email those to you. I don’t know if you
guys have any questions.

DR. PARTIN: I do have a
question. So, this recommendation or these
guidelines for prescribing psychotropics, who are you
proposing develop the guidelines?

MS. KALRA: DMS, and we’re
happy to partner with DMS and provide some
recommendations. We have studies from Florida that we saw that made sense for us to utilize as a state and we could share those with DMS as well.

DR. PARTIN: Thank you.

Anything else? Thank you.

Consumer Rights and Client Needs.

MS. BROWN: Hello. I’m Miranda Brown with the Consumer Rights and Clients Needs TAC. We met on February 19th. A quorum was not present, but the TAC did raise concerns about the medically frail attestation process and Kentucky HEALTH notices.

Our members shared that beneficiaries have gone to their providers to start their medically frail process but providers nor beneficiaries haven’t heard anything back from the MCOs.

And while we understand that this may not be a concern in the near future with yesterday’s federal court ruling, the State still has options to appeal the court ruling or reduce benefits through a State Plan Amendment which would maintain medically frail protections as relevant. So, these are decisions that we will be watching closely still.
Mandatory copays continue to be a concern for our TAC. More than 140 Kentuckians have reported a number of issues they face with trying to access health care. For example, Medicaid recipients are sometimes turned away for services when their income is below 100% of the Federal Poverty Level despite the policy that those living in poverty cannot be turned away.

While this could be due to provider offices not reading the screens properly or not being aware of the income guidelines, the bottom line is that this policy is creating an unwelcome effect which is discouraging the use of important services such as preventive care, chronic disease management, behavioral health and substance use treatment.

We also discussed ADA guidelines. Our members have expressed concerns and made recommendations related to making accommodations for disabled individuals to participate in TAC and MAC meetings.

While DMS has stated that they will comply with the law, we are still seeking clarification on whether this means that DMS will cover the cost of interpretation and assistant
services directly for disabled members.

We made no recommendations, no new recommendations due to lack of a quorum, and our next meeting is scheduled for April 16th from 1:30 to 3:30 p.m., Eastern Time, but we have yet to determine a location.

DR. PARTIN: Thank you.

Dental.

MS. HUGHES: The Dental TAC did meet. I don’t believe they had any recommendations, though.

DR. PARTIN: Thanks, Sharley.

Nursing Home Care.

MR. TRUMBO: We don’t have a report because we didn’t have a TAC meeting. I am interested to know what the status of a LeadingAge representative is? Can we get the question to that organization?

MS. HUGHES: On the TAC?

MR. TRUMBO: No. On the MAC, Gary Marsh’s position.

MS. HUGHES: I did not know he had left.

MR. TRUMBO: Well, I don’t know what their status is but it’s been a few meetings.
MS. HUGHES: Until he resigns, he’s still an appointed member. You can go by the bylaws that were created and make a recommendation but that’s not up to me, or the Department, I should say.

DR. PARTIN: I’ll send him an email.

MR. TRUMBO: Okay. Thanks.

DR. PARTIN: Home Health.

MS. STEWART: Home Health met on February 19th. We did have a quorum and we have no recommendations at this time.

DR. PARTIN: Thank you.

Hospital.

MR. CARLE: Russ Ranallo could not be here today. He was unable to make it. You have a written report in your packet.

Just a couple of things. The TAC did meet on February 26th. A quorum was present. The TAC discussed several issues which have not yet been resolved. These include short-stay inpatient denials, utilization management issues, hydration denials and transportation issues.

As Medicaid staff were not able to attend the KHA Psychiatric and Chemical Dependency
For a Forum regarding the transportation issues, KHA has submitted a written report with questions attached.

The TAC also discussed the concerns that IPRO should be using clinicians to conduct clinical validation reviews instead of coders and billing specialists. Clinical validation involves a clinical review of a case to see whether or not the patient truly possesses the conditions that were documented in the medical record. DMS will be reviewing their contract with IPRO to address this issue.

The TAC also discussed the problem hospitals are having in not being able to bill Medicaid when Medicaid is the secondary when the patient refuses to cooperate with the primary insurer. This issue is also under investigation but has not been resolved.

KHA will be scheduling a meeting of hospital medical directors with Dr. Liu to discuss concerns with MCOs not following CMS national definitions and coding requirements for sepsis. We committed to try to work out these concerns before bringing specific recommendations on this issue to the MAC and this is somewhat of a big issue. So, it needs to be addressed.
Lastly, one MCO is only giving hospitals twenty-four hours to obtain an updated prior authorization when the CPT code of the procedure performed on the patient differs from the CPT code that was preauthorized.

This is unworkable and needs to be changed to address the fact that physicians will not always know the exact code prior to performing the procedure on the patient.

In addition, a twenty-four-hour time frame is not a reasonable time frame for the provider to update a CPT code. While seven days was discussed as a minimum time frame, KHA is currently requesting the policies for each MCO and will be working with its members to make more detailed recommendations for addressing this issue. That's it.

DR. PARTIN: Thank you. Any questions?

Next up, Intellectual and Developmental Disabilities.

MR. CHRISTMAN: Good morning. I am Rick Christman. I’m the Co-Chair of the IDD TAC.

We met on Wednesday, March
13th. We did have a quorum. Although we didn’t have any specific recommendations to pass, we had a lot of people there and we had a very good discussion.

I think I had mentioned in the past that one of the big issues particularly with the SCL waiver is large numbers of people because of their particular medical needs or their behavioral issues are really beyond the ability of the providers to continue to provide services for them.

Unfortunately, the way the regulation is set up – and I shouldn’t say unfortunately. I understand why this is. Under the regulation, we have to continue to provide services until we can find another provider.

Well, as you know, as you can imagine, this really makes providers unwilling to really serve people who they might suspect would be difficult to serve. So, this is an ever-growing problem. It’s kind of freezing up the system.

I think we’ve already identified 150 providers who felt they are serving people that they really can’t meet their needs which is not a good situation for anybody.

However, at this meeting and at this long discussion, Commissioner Steckel was there
which we were very happy to have her there, and as a consequence, we have formed a task force to look at this issue along with Pam, anywhere between ten and fifteen people and we hope to get started with those meetings right away to see if we can resolve this process.

As Pam also mentioned, the applications for the 1915(c) Waivers are out and we’re looking at that, but the one thing that she mentioned that we’re all delighted about is the increase of the patient liability to 300% of poverty. That’s huge for us and very welcomed.

And in closing, I just want to say I really feel like our TAC has been reinvigorated. I think the fact that the Commissioner is coming to the meetings, that’s been very refreshing and I feel like these TACs are going to be very helpful for us in the future. Thank you.

DR. PARTIN: Very good. Thank you. The Nursing TAC did not meet. Optometry.

DR. COMPTON: Steve Compton.

We did not meet either and we meet again in April.

DR. PARTIN: Thank you.

Pharmacy.

MS. HUGHES: I got a notice
this morning from Suzi Francis, the Chair. They’re having some new computers installed or something today. They did meet but there were no recommendations.

DR. PARTIN: Thank you, Sharley. Physician Services.

DR. McINTYRE: Hi. I’m Dr. William McIntyre, Vice-Chairman of the Physician TAC. We met March 15th. We had a quorum. We discussed provider enrollment, telehealth, public health trends, and we had a recommendation regarding modifiers for telehealth.

There are two modifiers we are recommending - acute versus chronic care so that those modifiers could be used by the Department and by the MCOs to track reimbursement and to track trends basically to help with reimbursement and also modifiers to show whether a provider was present with the patient when the telehealth visit was done or no provider.

For example, at some visits, you will have a nurse practitioner with the patient and the physician at some distance away and the nurse practitioner could help with abdominal outpatient, examination of throat, ears and so on.
The last thing we discussed was the reimbursement rate from the MCOs and from the Department for telehealth visits. There’s a proposal up in the air to reimburse those at 85% of what an office visit would be reimbursed for.

And it’s our position that that’s probably not going to be enough reimbursement to attract physicians to have the providers to invest in the technology necessary to do telehealth.

That’s everything that we had.

Does anyone have any questions?

DR. PARTIN: Any questions?

Thank you. Podiatry. Primary Care.

MS. HUGHES: Primary Care did not meet.

DR. PARTIN: Right. Therapy Services.

DR. ENNIS: Good morning. I’m Beth Ennis. I currently serve as the Chair of the Therapy TAC.

We wanted to thank the MAC for their assistance in these new task force recommendations. We realize that this came out of a meeting of ours being cancelled, and I apologize for creating chaos but we felt pretty strongly about it.
DR. PARTIN: It wasn’t just that.

DR. ENNIS: We did meet on the 12th. Depending on which rule you use, we may or may not have had a quorum. We’re going with no because we don’t have the ruling yet on video conference but we had been told previously we could. So, we had three in the room and one on video out of our six.

No major recommendations coming out because we didn’t have the quorum that we could call but we did discuss several things. We’re still having issues every January with codes being loaded incorrectly.

We do appreciate DMS’ work and a lot of the things that we had requested be updated were updated and we know that took a lot of work, but there are still some codes that have been on there since we were added five years ago that every time they get reloaded in January, they’re reloaded as visit codes instead of timed codes.

We’re still trying to work on processes to fix that because the MCOs go by that fee schedule, and, so, it impacts everybody’s reimbursement for a good four months until we can get it fixed.
We are working with MCOs on different issues and appreciate the ability of the TAC to do that.

We also discussed telehealth and are concerned about the 85% reimbursement after Year Two. I believe that the statute that was passed said that it would be parity. So, we’re looking into what that means.

We did get word from DMS that they were going to remove the differential for the Clinical Fellow for speech and that they would be billing under their senior therapist number.

We have asked for the same thing for PT assistants and OT assistants, and at this point, they’ve said no. So, we’re going to continue to dive into that because that’s going to impact access in providers pretty tremendously but that’s all we have. Thank you.

DR. PARTIN: Thank you, and that’s it for the TAC meetings.

I’d like to go back for a minute to the recommendations from the workgroup. The TAC Chairs will need to let Sharley know where your meetings are going to be held so that she can post that appropriately. I’m sure that there will be
other discussion as we move forward on this but that
is just something that came to mind just now as far
as public notice for those meetings.

MR. CARLE: Stephanie, given
what we submitted, obviously the Department hasn’t
had a chance to review that; but I guess what we
would ask for is that the review and communication of
any concerns that would be had on the side of DMS,
that’s discussed maybe with the Executive Committee
representing the workgroup and we do that much prior
to our next meeting, if possible.

MS. BATES: Right.

MR. CARLE: I know that
certainly with everything that’s going on with the
waiver and everything, we certainly understand.

MS. BATES: Right. This was
the first I saw these recommendations this morning.
And actually I was in the Secretary’s office
obviously earlier this morning, and, so, we talked
about how we need to get together and discuss these.
So, absolutely.

DR. PARTIN: Thank you. So,
moving to New Business, we would like to schedule
reports from the MCOs as we have done in the past so
that we can get an update on where the MCOs are with
everything. We’ve done this before, so, it’s not anything new but we’ll need to get that scheduled where we have a couple of them report at each meeting.

MS. HUGHES: Do you want two? I was going to ask, did you want a couple to report?

DR. PARTIN: I think so.

MS. HUGHES: That way, we can get them all in during the year.

DR. PARTIN: Yes.

MS. HUGHES: About twenty to twenty-five minutes?

DR. PARTIN: Twenty minutes each.

MS. BATES: So, do you want to schedule certain topics for them to go over?

MR. CARLE: Well, it would be similar to what we have done before. I asked for this to be put back on the agenda, looking at the quality outcomes, access metrics which they already post, ED utilization. I’d like to see the cost per member per month.

Obviously they need to report their financials which would include their margins and any new programs innovative that they might have
that differentiates them from somebody else.

So, Stephanie, while you came back up, I’ve got a question. Does DMS go back and audit the RFP that they originally sent to these individuals that have been selected, not the new process, but the old process that selected the five and do you audit if they are in compliance with what was actually in the RFP?

MS. BATES: Not necessarily the original RFP. We just go by the current contract.

MR. CARLE: But you do have an active audit system that audits how they are complying with the contract.

MS. BATES: We have a whole team that’s dedicated to that contract and we’re looking at that. As a matter of fact, I’ll just go ahead and let you know that we’re kind of looking at how that is set up and how we want to do it differently when we implement the new contracts under the RFP that will be awarded in 2020 because we feel like we could be a little bit more efficient.

Obviously, in state government, we fall into the same old thing and, so, we don’t want to do that. We want to reevaluate how it’s set up.
MR. CARLE: Good, because my next question was going to be, is that within the Department of DMS or is it in an audit function in, let’s say, Accounting or someplace else?

MS. BATES: No. Right now it’s mainly within DMS. Where the new RFP will include a lot more strength in the foster care, we’re going to have more of an audit capability for DCBS to audit their part of the contracts. So, that’s just part of the whole foster care transformation.

That’s kind of what we’re evaluating right now is how the managed care oversight is set up and if we do need to bring in outside entities to do that.

MR. CARLE: Okay. That’s right where I was going.

MS. BATES: We are definitely looking at that and we know that we are just short on staff really. The bandwidth is just not there.

MR. CARLE: Okay. Thank you.

MS. STEWART: Stephanie, I have a question related to that. Is there opportunity for you to do a patient satisfaction survey type thing with providers on how we feel like the MCOs are doing?
MS. ALDRIDGE: Which we’ve asked that before.

MS. BATES: And I believe that we have something like that. Let me look and see what all the satisfaction surveys that we have going on right now. There are so many things you wouldn’t believe, like, how many that go on behind the scenes that you might not know about.

I’ll get a list of the surveys that the MCOs are required to do now. I know we from Medicaid don’t necessarily send something directly out but that’s a good idea.

MS. ALDRIDGE: And, Stephanie, yesterday I got an email from some of our DME providers. They’re starting to get emails from a Molina.

MS. BATES: Okay.

MS. ALDRIDGE: And they’ve never heard of them before. And when they pull it up, it’s a new MCO for Medicaid out of Louisville. So, is this the new MCO?

MS. BATES: No. We are not contracted with Molina.

MS. ALDRIDGE: And you’re not going to?
MS. BATES: I can’t comment on that. I have no idea if they would bid. They are not a current MCO now.

MS. ALDRIDGE: Well, I know they are not current but it’s been discussed, I think, when it was Commissioner Miller before that you all were not going to expand more MCOs in the state. So, is that still the way it is? You’re going to try to keep it to a minimum?

MS. BATES: So, we’re still in the middle of the procurement process and I really can’t comment. And we’re actually in a blackout period to where we’re not talking to anybody at this point.

MR. CARLE: Teresa, I think that Molina is interested in applying through the process to become a provider in the State of Kentucky.

MS. ALDRIDGE: Well, they sent information out but they didn’t send any--what I’m hearing, they’re not sending out any like fee schedules or anything.

DR. PARTIN: United Healthcare is also sending out emails.

DR. GUPTA: Stephanie, could
you also ask the MCOs to present their translation services?

MS. BATES: Sure. What I will do with that is I will go ahead and outreach them and kind of get an update on where they are on those and kind of send it to you all, but, yes, we will let them elaborate.

MR. CARLE: But we would like also, as was brought up, the patient satisfaction surveys directly from the patients, not necessarily from the providers but the patients as well, but I think the providers is a great idea.

DR. PARTIN: And, then, one other thing I would like to add is for them to report on their provider access, the primary care and the specialties.

So, Sharley, would you contact the MCOs and start to get that going?

MS. HUGHES: Yes.

DR. PARTIN: Okay. Great.

Thank you.

MR. CARLE: I think last time we went alphabetically. I think we started with “A”, so, we can start from the back and come forward this time.
MS. HUGHES: If you want to do that, we can.

MR. CARLE: It makes it easy.

DR. PARTIN: Anything else on that? Thank you.

Then, moving on to the next item of New Business, we have talked in the past about responses to TAC recommendations that were not very helpful, and the Commissioner asked me at the last meeting to bring forward some examples of that.

So, what I did is I asked some of the TACs for some help and, then, I also went through some of the recommendations, the responses to the recommendations from the TACs.

And, so, I’ve got some examples of things. And this isn’t meant to be critical. I want to do this in a way that is constructive so that it can be more helpful when we’re getting the responses back.

So, back in March, this was to the Consumer Rights and Client Needs TAC. There was a recommendation that the medically frail screening questions be asked of the Medicaid applicants and enrollees on the Benefind system or paper application.
And the response was: DMS is currently in the process of making changes to the Benefind system and that was sort of like a non-answer. It didn’t really respond to the recommendation.

Another example from that same report was to streamline the grievance and appeals process of the 1915(c) waivers and 1115 waiver. And, then, it says: Redesign efforts will review the grievance and appeals process within the rules and regulations mandated by CMS. Certainly, we would expect DMS to review things as CMS requires but that really didn’t answer our speak to the recommendation.

Another example – this is from a Behavioral Health TAC meeting – the recommendation was that DMS commit to creating a stakeholder advisory council.

And the response was: The Department will follow federal regulations regarding advisory councils. Again, that didn’t really speak to the recommendation. It just wasn’t an answer, I don’t think.

Another example, DMS to pay the cost of background checks for persons hired to
deliver participant-directed services in the Home- and Community-Based waiver and not have the Medicaid waiver recipient pay.

And, then, the response is:

Preemployment requirements will be reviewed during the 1915(c) HCBS waiver redesign which didn’t speak to the recommendation at all.

I have more examples if you want.

MS. BATES: I think you’ve made yourself clear.

DR. PARTIN: Okay, but I think it’s important for all of us. In order for the MAC to be advisory to DMS and for the TACs to bring the issues forward that the responses to the recommendations be more clear and more constructive so that they be more helpful.

MS. BATES: Sure. Thank you.

DR. PARTIN: Thank you. Does anybody have anything else they would like to add?

If nobody has any other business, I think this might be the fastest meeting in the history of the MAC.

MS. BATES: You’re welcome.

DR. PARTIN: So, any other
business? No. Would somebody like to make a motion to adjourn?

MS. ALDRIDGE: I make a motion.

MR. TRUMBO: Second.

DR. PARTIN: Teresa motions.

Jay seconded. All in favor. Opposed. So moved. Thank you all.

MEETING ADJOURNED