CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

January 24, 2019
10:00 A.M.
Room 125
Capitol Annex
Frankfort, Kentucky

MEETING

APPEARANCES

Elizabeth Partin
CHAIR

Chris Carle
Julie Spivey
Steven Compton
Sheila Currans
Ashima Gupta
Bryan Proctor
Peggy Roark
Jerry Roberts
Julie Spivey
Melody Stafford
Susan Stewart
Jay Trumbo
COUNCIL MEMBERS PRESENT

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AGENDA

AGENDA
(Continued)

DR. PARTIN: Good morning. We're going to call the meeting to order. Before we get started, I just wanted to make two notes. Teresa Aldridge, our Secretary, was not able to be with us today because she had to attend a funeral.

And William Schult had to resign because his new employer would not allow him to travel to the meetings and he represented Consumer Advocacy and Disabled Persons. So, I imagine that group will be submitting a name to the Governor for appointment of somebody else to his spot.

So, moving along, we had the minutes from the November meeting. Would somebody like to make a motion to approve those?

MR. TRUMBO: So moved.

MR. CARLE: Second.

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

Moving along to Old Business, I'm going to skip around here just a little bit. I'd like to go down to (b) regarding requesting an AG opinion regarding requests by TAC members to be able to use Apple FaceTime, Google Hangouts, etcetera when a member cannot attend a meeting.

The question was can the

meeting be held in a public place just as it is now; but if a member cannot attend, could they attend via one of these digital ways.

And, so, a letter has been sent to the Attorney General by our Secretary and we will await a reply to that.

And, then, moving back up to (a), reimbursement for vaccines for those over age nineteen to look at covering the cost of the vaccine and administration, and DMS was going to provide some reimbursement information to us. Do we have that?

COMMISSIONER STECKEL: I am not sure what information that we were supposed to provide to you that we haven't already provided.

DR. PARTIN: Initially we were requesting reimbursement at cost so that practices could provide the vaccines. And, then, when we discussed it further, you said that that might not be possible but that you didn't know because you didn't know what the reimbursement was.

And, so, we were going to be provided with the reimbursement for the various vaccines, what Medicaid was reimbursing for those.

COMMISSIONER STECKEL: That information is posted on the fee schedule. So, the

first MAC meeting I attended, that was true, I did not know the reimbursement methodology, but we have responded to this question after that meeting and the second meeting, and the fee schedule is posted online. So, you have ready access to it.

DR. PARTIN: Could somebody tell us where that is online so we can access it?

COMMISSIONER STECKEL: We'll be glad to provide it in the minutes.

MS. HUGHES: On the link to the Homepage for Medicaid, if you go over to the right, there is a link that says Fee Schedules.

DR. PARTIN: Okay.

COMMISSIONER STECKEL: And we'll provide it in the packet that goes out to you all.

DR. PARTIN: All right. Thank you.

And, then, I see in our packet, we got some responses to questions that the MAC had asked at the last meeting but we just got those today. And, so, I've just barely skimmed through it in the past few minutes.

But one of the questions was regarding recoupment of provider reimbursement. And

I think that members of the TAC understand the rules as far as CMS and requiring recoupment if the patient isn't enrolled.

What the problem is is that when providers check online to see if the patient is current and they are seeing online that they are current and, then, going ahead and seeing the patient and billing and, then, three years later or two years later being told that that money is recouped because the patient wasn't participating at that time.

So, the problem is is that the information online is inaccurate when the provider goes to confirm whether or not the patient is current.

COMMISSIONER STECKEL: And we've looked into this extensively as you asked on the first MAC meeting I was here and the second MAC meeting and now the third MAC meeting.

The information is accurate on HEALTH.Net, KYHEALTH.Net but the federal government and we do retroactive eligibility, and sometimes that's what happens and that's the way the rules are designed.

I understand it's a Catch-22. We've looked at ways to try to address it, but just

like we get that impact when they do retro adjustments to the dual eligibles from the feds to the state and we end up having to pay more for our duals. This is the way the system is designed; and as of yet, we've not been able to figure out a way to address it.

DR. PARTIN: So, if the information is accurate online, then, how can the patient not be current three years later?

COMMISSIONER STECKEL: If there is information that's found in a search, then, they may not, or if the decision that was originally made wasn't originally made correctly. Now, I don't know why three years.

So, if you have a three-year issue or a two-year, it should be within a year. If you've got a longer one, then, you need to reach out to our Provider Enrollment, or not our Provider Enrollment, our Eligibility Division and try to resolve that.

DR. PARTIN: That has happened in the past. I don't know that it's happening----

COMMISSIONER STECKEL: So, if it's not happening--I'm sorry. I'll be calm.

DR. PARTIN: That's good.

COMMISSIONER STECKEL: If it has happened in the past, we need to know is it happening now.

DR. PARTIN: Yes, it does happen now.

COMMISSIONER STECKEL: Then bring them to me. I want any example you have of an eligibility recoupment that's more than a year old. Bring them to me personally.

DR. PARTIN: It's a problem even if it's a year old, and I guess that's why we keep on putting it on the agenda because it's not fixed.

COMMISSIONER STECKEL: The answer is not going to change, Ms. Chairman, Madam Chairman. It's not going to change. So, we could spend our valuable time, your valuable time where I'm saying the exact same thing to you or we could do something else.

If you have something that is an old recoupment, send it to me and I will personally make sure we look at it and see what's going on with it. Unfortunately, this is one of the Medicaid systems that I wish I could say it made sense but it doesn't but it is the system we have to

work within.

Now, I will be glad to say this at every single MAC meeting if you want to put this on the agenda but it's going to be the exact same answer unless there's a federal law change.

DR. PARTIN: All right. If anybody has any issues as far as recoupments, please bring them forward.

COMMISSIONER STECKEL: And everybody has, I hope, my email address. It's carol.steckel@ky.gov.

DR. PARTIN: Next under Old Business was a question about copays. And I see that there's a response here but I'm still not clear on who collects the copay. If the patient is being seen and they're also having a lab test done at this time that they're being seen, how is that copay collected?

And I guess further, if a patient comes in for lab work and they're not seen for a visit, then, they have a copay for lab work but the providers are drawing the specimen but they're not doing the test. For instances, does Lab Corp send the patient a bill for a $3 copay? So, that's two questions.

MS. BATES: So, in the document

that you received, everything is outlined there.

So, if - and I'm not going to get into the weeds right here - but if the lab is not connected to that visit, the actual lab - and that's what it states in here - then, a copay is deducted. The laboratory would probably just be paid, was it $3 less.

DR. PARTIN: So, the laboratory would have to send the patient a bill?

MS. BATES: It's no different than the provider. So, as a provider, if there's a $3 copay for a visit, then, if the charge was $50, you would get paid $47. Does that make sense?

DR. PARTIN: Yes, I understand that part. My question is two parts. One, is there a copay? In the example that we have here, like a person comes in with a sore throat and you do a Strep screen----

MS. BATES: That's associated with a visit and all of the codes and all of the logic is in this document.

DR. PARTIN: Okay, but I haven't had time to read it.

MS. BATES: Once you read it, if you still have questions, the MCOs can definitely

answer. And if you need something, I can answer it, but I would prefer that you all look through the document and you can do whatever.

COMMISSIONER STECKEL: What Stephanie has done and her team is provided the logic of what we used, so, down to the claims' level. So, this is the document that will answer your questions.

DR. PARTIN: Okay. So, the response says that you have previously answered this question. Please refer to the attached document. All I've got is this piece of paper.

COMMISSIONER STECKEL: It's in your folder.

DR. PARTIN: Okay. I had like five minutes when I opened my folder to see this. So, I have to ask the question because I don't have the answer.

MS. BATES: So, the answer is in this document.

COMMISSIONER STECKEL: And we recognize that, and not just this body but there have been a variety of questions about who pays what and when and how and when you layer on those visits. That's why Stephanie developed this document so that this tells you exactly how our logic works and will

walk you through all of those questions.

MS. BATES: And the reason it's hard to answer that here is because you have to have the code for the test, and this is all the way down to the code level for the test.

DR. PARTIN: And I sent Sharley codes.

MS. BATES: And I sent Sharley this. So, yeah.

DR. PARTIN: Okay. So, the other question is, and I don't know if that's answered here or not, but if a patient is seen today and they have high blood pressure, for instance, and they have to come back tomorrow for fasting lab work to check their cholesterol, that test was ordered today but the patient has to be fasting and they're not fasting today, so, they have to come back tomorrow.

So, they come back to my office. I don't do that test. I draw the blood. So, is there a copay for that?

MS. BATES: Yes, depending on if it's listed here, the code for the test is listed.

DR. PARTIN: Okay. And the lab would have to collect that copay.

MS. BATES: In that situation, it sounds like they would.

DR. PARTIN: Okay. Thank you.

DR. ROBERTS: Under DME supplies and prosthetic devices, I understand the $4 copay; but if a patient comes in and receives in my profession shoes and a brace, two specific items, is that $4 for each item or $4 for like the encounter?

MS. BATES: It's not supposed to be but we've heard reports that that's happening. So, I did send that out, by the way, to the MCOs, so, they're looking at that. So, no. If it's the same day, same provider/patient combination, it should just be one.

DR. ROBERTS: A lot of the braces can have three, four, five codes. That changes things significantly.

DR. BATES: Right. Number 6 on the very front of the page of this covers that.

DR. ROBERTS: Yes, but you didn't give me an answer. I know you sent this out to the MCOs in November after we discussed it and they still haven't provided a response. What is their time frame for giving a response to the question we asked in November?

MS. BATES: Was it the question you just asked?

DR. ROBERTS: Yes.

MS. BATES: So, I said that there should only be one copay in that situation.

DR. ROBERTS: Should. Okay. So, that's the answer, one copay.

MS. BATES: That's correct.

DR. PARTIN:

DR. GUPTA: I just have another question about copays. It's not related to this document. It's about this other document that I think was sent out after the last MAC meeting for the enrollees.

I just had a question about Number 8. It says: Can a provider refuse to see me if I cannot pay the copay for a specific service? And the response is: If your income is 100% or below Federal Poverty Level, you cannot be refused services.

So, how do we as a provider know if they meet that criteria?

MS. BATES: It's denoted in KYHEALTH.Net. Provider education that was sent out actually has screen shots of that.

DR. GUPTA: Okay, but those patients still would have a copay?

MS. BATES: Yes.

DR. GUPTA: But we can see them still or we have to see them even if they cannot pay that copay?

MS. BATES: Correct.

DR. GUPTA: And that would be clearly outlined when we look it up?

MS. BATES: Yes.

DR. GUPTA: Why do they have a copay, then, if they're not going to pay their copay?

MS. BATES: Well, if they're exempt, if they're a child or whatever, then, they won't have a copay.

DR. GUPTA: It just seems like it makes it more confusing to still have them pay a copay, but if they don't pay it, we still have to see them. It just seems like it would be a lot easier just to not make them have a copay.

MS. ROARK: Thank you for your comments.

DR. GUPTA: It's going to make it more confusing for us, I think.

DR. ROBERTS: One other

clarification. As a physician supplier, if I see the patient, render services, I collect my $3 copay. If I dispense them items, do I have to collect the $4 copay on top of that because the majority of podiatrists are both physician and DME suppliers? So, which copay or both would I have to collect?

MS. BATES: That's too in the weeds for me. I would have to look down in the document. So, if you want to send it, you can if it's not already answered in the document. I don't want to give an answer that's incorrect.

DR. ROBERTS: Okay.

DR. PARTIN: And now as I have had a chance to look at the responses to the MAC questions, actually, what you all have done is looked at the agenda and, then, given us a sheet with responses to what's on the agenda.

COMMISSIONER STECKEL: Correct.

DR. PARTIN: And it makes it really difficult for us to discuss anything because we didn't have an opportunity to read this. I'm reading this, but, then, I'm not listening to what other people are saying.

COMMISSIONER STECKEL: Well, Madam Chairman, the point of that is that as I've

said to every TAC and as I said to this body the last MAC meeting we had, this is not the forum to bring individual complaints about individual businesses or claims or issues that are focused or have been asked and answered.

This, we hope, will become what it was intended to be at the beginning and that's a forum to advise the Medicaid agency.

So, the point there is these questions have been asked and answered. If you want education on what the copays are, that's a different question and a different forum. If you want questions about the claims processing system, different questions, different forum.

DR. PARTIN: With all due respect, Commissioner, I think that everybody here in the audience and on this Council is interested in the answers to these questions.

COMMISSIONER STECKEL: And we've given the answers, Madam Chairman. You just don't like the answers.

DR. PARTIN: No. Some of the answers are non-answers. They're like-----

COMMISSIONER STECKEL: Tell me what is a non-answer.

DR. PARTIN: Okay. I will go through the responses----

COMMISSIONER STECKEL: If you've made that judgment, based on what have you made that judgment?

DR. PARTIN: Commissioner, I don't want to get into an argument with you and I really don't think that that is appropriate for us to do at this meeting. I will bring examples to you.

COMMISSIONER STECKEL: Well, Madam Chairman, and I'm not trying to get into an argument with you. I have a sincere faith in what a MAC can do. I've been a Medicaid Director in multiple states. I've seen what MACs can do in a variety of states even when I wasn't working in them, and I don't think that this MAC is fulfilling that potential.

Now, how else can I express that but to say to you all what I believe and for us to have an open dialogue about it. I mean, your mission is to advise the Medicaid agency.

DR. PARTIN: If we don't have the information, it's difficult for us to advise. And I understand in a public forum like this there are things that you can't talk about publicly because

they're in the process and you really can't talk about contracts or things that are going on in Medicaid that have not had a final decision; but it's difficult for us to be advisory----

COMMISSIONER STECKEL: What have I not provided to you all? I mean, help me understand this. That's all I'm asking is if you've made a judgment that I'm not providing information, okay, what have I not provided?

If you've made a judgment that I've not answered the questions, what questions have I not answered? I promise you all I am not trying to be argumentative. I'm just trying to get us all to a point where we're working together.

DR. PARTIN: I will bring that information to the next meeting.

COMMISSIONER STECKEL: Okay, but--okay.

MR. CARLE: So, Commissioner, based on that, were you prepared as part of your update to us, were you going to review this information that was in the packet because it does go, as Beth mentioned, Dr. Partin, it does go right down the agenda and tries to answer those questions. Was that part of your update?

COMMISSIONER STECKEL: We would be glad to. We weren't intending to because we----

MR. CARLE: You put it in writing.

COMMISSIONER STECKEL: But what we did add to our part of the agenda and the updates is a true update on the major programs that are going on, and I wanted to raise an issue that was raised in one of the TACs that is a policy issue that we're going to be exploring with them. So, we had put that all under the Commissioner's comments.

MR. CARLE: And I agree with your point that it shouldn't necessarily have to be reviewed here at the meeting. We can use our time more beneficially.

However, just like you've requested some things in your memo related to what you feel the TACs should be addressing, we would, then, request that you put a timetable on yourself and your team to get this information out to us so we can prepare for the meeting in advance so that we will not ask you that question and belabor it once again.

COMMISSIONER STECKEL: That is a fair----

MR. CARLE: We will do our homework if you do your homework.

COMMISSIONER STECKEL: Yes. That is a very fair point and we will, absolutely. That's a very good point.

DR. PARTIN: The next item on the agenda was an update on House Bill 69, and the response is DMS is limited to what we can and cannot say because of model procurement laws. DMS is required to follow the model procurement laws outlined in KRS Chapter 45A. We are moving forward with implementation.

COMMISSIONER STECKEL: And Carl Ishmael, our Director of Program Integrity, again, this is where, Carl, I'll have you talk about where we are in the RFP process. There is a certain point when the RFP hits a point that we, then, have to go what I lovingly refer to go dark, that we really can't talk about it, but, Carl, why don't you address it.

MR. ISHMAEL: Thank you. This is Carl Ishmael and I'm the Director for the Division of Program Integrity.

We provided a few updates with as much information as we think we can due to the

model procurement laws. What we have done is there's a lot of things that we also have to take into account with this such as some of the existing systems that we currently use.

We've also used a substantial amount of resources that we have dedicated to this. Several of our subject matter experts are also working with our business partners such as the Office of Administrative and Technology Services.

For some recent updates, we've had several ongoing meetings that's been happening in the past few weeks. We're ironing out some of the requirements and still working through all of those.

We've also involved our federal partners who have oversight over part of Provider Enrollment and also over part of our CMS systems where they provide funding and also approval for certain things that are related to systems.

So, we currently have some future meetings scheduled with them on an ongoing basis and we're working through compiling, making sure that we have all of the requirements taken into account.

Kind of as some background information, if you will indulge me for a minute, I

want to give you a little bit which we've talked a little bit about at one or two of the other meetings is a little bit of what we currently do with Provider Enrollment, just some statistics.

So, we receive anywhere from 600 to over 1,000 new provider applications a month to participate in Kentucky Medicaid.

On top of that, we also receive around what we call anywhere from two to three thousand what we call maintenance items on a provider's profile, and what that means, that could be such a thing as an address change. It could be an update to bank account information that we're required to do. It could be a number of different things that are updated.

So, with that, we also track all those applications that come into Medicaid now. So, when an application or an update is sent in, when those are received, those are imaged and they're given a date stamp as to when they are received and, then, those are tracked through the entire process.

So, I just wanted to kind of give you an idea of a few things that are going on with Provider Enrollment and the level of effort that's involved in processing applications and things

now.

So, we have been working towards automating several of those systems. We also have to take some of those processes that we're working on automating into account in this procurement or this potential procurement.

Unfortunately, I can't give you any details as to what the actual requirements are going to be within the RFP or actually dates of when we expect things to be actually released because I think due to the model procurement laws because one thing we don't want to do is we don't want to jeopardize this process where we would have to go back and start over because that would just extend time frames and stuff and we don't want that to happen.

I'm not sure if there's anything else I can provide at this point.

MR. CARLE: So, I'm very consistent, Carl, I'm going to ask you that question you just kind of brought up. Are you on time? Are you going to be able to meet your deadlines?

MR. ISHMAEL: We are working towards meeting the internal deadlines.

COMMISSIONER STECKEL: Now,

that's a bureaucratic answer, isn't it?

MR. CARLE: I was going to say, it's a yes or no answer. You're either pregnant or you're not.

MR. ISHMAEL: At this point in time, we believe so.

MR. CARLE: Okay. Thank you.

COMMISSIONER STECKEL: I have to give you a hard time. Thank you. You did great.

DR. PARTIN: Next on the agenda are updates from the Commissioner.

COMMISSIONER STECKEL: Madam Chairman, also you all had asked about the Behavioral Health TAC on the medically frail form and that will be reviewed six months after we've gone live with it; but something else that we've done is we've asked the MCOs that where they have attestations to go ahead and process those.

So, we're trying to make sure that there's not a backlog of the attestations once we do go live on April 1st but, then, we will be reviewing that medical frailty form after six months of being alive.

DR. PARTIN: And as part of that review, will we be able to have some input

before that's finalized?

COMMISSIONER STECKEL: Certainly.

DR. PARTIN: Thank you.

COMMISSIONER STECKEL: So, I'm going to start with SB 5 and our pharmacy program. I am very, very pleased to announce that we have a Pharmacy Director. Jessin Joseph has joined us. He is a PharmD, MBA and is currently getting another degree that I still cannot remember.

DR. JOSEPH: This is Jessin Joseph. Pharmaceutical Outcomes and Public Policy at the University of Kentucky.

COMMISSIONER STECKEL: So, he started in our office of Data Analytics. So, he has that data analysis mind set. We have convinced him to come to Medicaid and has been helping finalize SB 5's report that we're about to release in the next two to three weeks and now will take on all issues related to pharmacy in Medicaid.

A lot of very good experience and we are both proud, thrilled and excited to have him on board. Jessin Joseph. Any questions of Jessin?

And as you probably have

learned over the years, our email addresses are relatively easy, but his name is J-e-s-s-i-n.Joseph@ky.gov, but you will be hearing a lot from Jessin over the next few months as we talk about pharmacy reimbursement and MCOs and PBM's and on all of those issues.

Any questions? Thank you, Jessin. Kentucky HEALTH.

MS. BATES: I just wanted to give a quick update on what's going on with Kentucky HEALTH, the 1115 waiver.

We're still as of today all systems go for a go-live of 4/1. So, we are meeting internally and doing systematic things, meeting with the MCOs about systems; but as far as Kentucky HEALTH goes, everything is the same as of today and I really just wanted to entertain any questions that you all have about the waiver.

DR. PARTIN: Do you expect that the lawsuit that's been filed will have any impact as far as being able to go forward?

COMMISSIONER STECKEL: You could answer that question as well as we could. And I don't mean to be flip, but it could. It all depends on what the Judge rules, and we have had to

have a delay because of the government shutdown and the federal DOJ's involvement, but it literally is a function of what the Judge decides.

We are - and I can say it because I've been watching everybody - but I think when the implementation was remanded earlier, there were a lot of lessons learned in that process that now we're correcting so that if there is a delay or if there is a change in the implementation date, we now know how do we do things like sending invoices about premiums, not doing that. So, we're building into the system a what-happens-if scenario.

DR. PARTIN: Thank you.

MR. CARLE: So, Stephanie, I've got a question. You heard about what WellCare is going to try to do for the eligibility requirements.

MS. BATES: I don't know.

MR. CARLE: So, WellCare to help Kentucky Medicaid members meet work requirement. So, I wanted to know if you're aware of that.

MS. BATES: They have a system called WellCare Works that has been vetted through the Department, yes.

MR. CARLE: Okay. So, what's your thoughts about it?

MS. BATES: Anything that we can do to help people get a job is great. It's been vetted all the way through the Secretary's Office.

MR. CARLE: Okay.

COMMISSIONER STECKEL: I know you directed that at Stephanie, but anytime we can use one of our partners or five of our partners and our thousands of individual providers to help our beneficiaries, that's a win/win.

So, I know WellCare Works has gotten a lot of publicity recently but there are other MCOs and other organizations throughout the state. That is an exciting thing for me coming from out of state to look at and see how everybody has come to the table - Workforce Development, Education, all the community development groups and the MCOs - to help our beneficiaries because, in my opinion, that's going to be the way we "solve" the Medicaid budget crises is if we have people empowered to make better decisions about their health, to get into the workforce and get employer-based insurance and not have to depend on a safety net so that we can focus on those people that depend on the safety net.

The way I describe it is instead of it being a net over somebody, it's a

trampoline to help them up.

MR. CARLE: I would agree. So, I guess the next question, though, then, and I know Carl can't answer this, but is it going to be an expectation moving forward - it's probably not in the current RFP - but is it going to be an expectation moving forward that whoever is left standing would have to provide this same kind of outreach?

MS. BATES: So, that particular thing was not a requirement but any MCO that's contracted with the State is going to have requirements to put forth any policy or any program that we implement.

COMMISSIONER STECKEL: And there is going to be a requirement to support the goals and the mission of Kentucky HEALTH.

This RFP, and why don't we just talk about it for a little bit because we still can right now, but the RFP that we're hoping to design for the new process is one that is going to be instead of widget counting, it's going to be outcomes measurement.

So, okay, you did four lab tests but what does that really mean for the health of the person?

It's going to have penalties that aren't a slap on the wrist. Having come from an MCO and a very good one, but I want it to mean something if they don't comply with what we've asked them to do and some of our penalties are not that meaningful.

We're also going to do more in the expectation area around quality measures and what we expect and how we're going to measure around quality, particularly not doing a boil-the-ocean type quality measurement.

They're still going to have to do HEDIS. They're still going to have to do their NCQA work that they have to do to be certified, but we're going to start looking at three to five quality measures that we think will move the needle on specific Kentucky health conditions.

That way, they can focus on those. They can move the needle and, then, in three years, we can see have we been able to move the needle? If so, can we move on to another issue.

MR. CARLE: A great example of that might be a more focus on diabetes.

COMMISSIONER STECKEL: Correct. Correct. COPD, correct. So, I think people will be

pleased with the direction we're going in the RFP and the new contract. Stephanie and her team have done an extraordinary job of how do we move into the future? How do we trust but verify and how do we maximize the partnership with the MCOs much like WellCare Works?

MR. CARLE: Thank you.

COMMISSIONER STECKEL: You're welcome. Jill.

MS. HUNTER: Good morning. I wanted to take just a moment to talk with you all about what's going on in 1915(c) redesign.

So, recently, we've had the opportunity to host several of our advisory panels. We have one overarching advisory panel sort of like the MAC and TACs only by no means that formal but for the project.

So, that overarching advisory panel will have representatives from each of the swim lane advisory panels working on unique projects within the redesign. They'll, then, communicate up with a representative and be able to talk with us. It works for MACs and TACs, so, I don't know why it wouldn't work there. So, we just carried the similar process over and it seems to be very effective.

So, we've had those initial meetings. As you know, the waivers went up on January 7th for public comment. The public comment process worked beautifully, worked as designed which is what my technology people tell me all the time. So, now I understand why they say it. It makes complete sense because we've pulled those waivers back down.

What we were hearing in the comments caused us to pause and say, well, there's some confusion. It doesn't say that. Well, absolutely it did. What they were sharing with us in comments was a direct arrow to you all missed here, go back and rethink.

So, it has given us an opportunity regroup and start over, clean up where we need to, do exactly as the public comment process was intended, listen, learn, change, move forward.

So, we will re-post those waivers I'd like to say as quickly as humanly possible but that infers that we won't give adequate time to the process. So, there's not going to be anything quick about it. We're going to take appropriate time, make sure we have those questions answered, go through a formal process and, then,

re-post those waivers and give an additional full thirty days of public comment. I would rather have too much public comment than not enough. This is the right thing to do in my heart because it gives everyone a chance to say I read that. It does or doesn't make sense. Please know these facts.

Then when they come back down officially from public comment, we'll read through, of course, as those public comments. I get daily reports which I keep in my green folder of what's going on because I want to read those public comments. I want to hear what folks have to say as well as my team and Navigant.

Then when the waivers come back down, affect change where necessary. If changes to what we had initially posted are substantial, it will require that they go back out for public comment again. So, it's going to take the time it needs to do it right.

Then they'll go on to CMS with an opportunity for CMS to review because they have to say grace over it so we can keep getting that money which we absolutely want. Once they say grace, we'll complete regulations that comport with those waivers. They're sort of how do we make it go in Kentucky.

So, we'll complete those regulations and move forward.

Again, this part of redesign is only Phase I, an opportunity to paint the picture as it exists today, ensure that we have some equity and consistency across the waivers and language so that our providers are better able to administer versus trying to guess who is on first, also working toward our end goals, providing the very best services we can for those citizens that we have the privilege to serve.

We're also doing a rate study. Every time I say rate study, my providers on that side of the house get very excited and hope I found a lot of money. I have not.

So, it's zero-sum game with that rate study, but what we're doing is taking a snapshot of how we are reimbursing providers today, what the picture is. And then we need to ask the question, are we doing it consistently, fair and equitable across the waivers?

If we find a lot of money, we'll add it into the rate study but at this time, it's a zero-sum game. It's just taking a picture. The rate study is another process, another one of

those swim lanes with its own little council at the top.

The good thing about the rate study team is I'm very pleased to say not only do we have providers from each of the waivers, we have a recipient on the rate study team. So, it's very exciting.

She laughs because she's like I have no idea what's going on here. So, we'll sit and talk, but it's really good for her to understand what goes into the services and how is she an integral part of it. So, she has been very excited as well as the providers and, again, across the waivers.

That's going to take some time. We're doing a complete study and we'll be sending out a rate study to each individual provider, giving them a chance to complete it, help us paint the picture. So, it will take some time but, again, slow, very intentional, let's do it right.

Beyond that, I think that's a pretty good picture of what's going on in 1915(c) redesign world - slow and methodical. It's going to take time. Let's do it right.

Any questions? Anything I can answer for anyone?

COMMISSIONER STECKEL: And before we take questions, I'd like to brag on Jill and her team. We had the Executive Director and the Assistant Executive Director of the National Association of States United for Aging and Disability - that's one of our tests to become a Medicaid Director is you have to know that - but they're the organization that represents all of the Triple A's, the aging organizations and the disability organizations nationwide.

They were here to meet with Commissioner Gadds and with Jill and Pam, her team, and they are hearing about the work that Jill is doing on this redesign as a best practice.

So, they've asked us to present at their annual meeting and they're excited to learn more details, but they're also here in town or were here in town to meet with our two agencies and eventually BHDID will be brought in, too, to make sure we're maximizing all of the Medicaid resources for the waivers and for the work that those two sister agencies, not only those two but others, but specifically those two in the aging and disability community, that we're maximizing all of our resources in there.

So, we're really excited to be able to bring in some national folks to help us out, too, on top of the best-practice work that's being done. So, I just wanted to brag for a minute.

MS. HUNTER: Thank you.

MS. STEWART: Jill, I have a question. Is it possible to get a list of who your teams are so that if we have questions, we can reach out to them so that we can make sure who our contact is?

MS. HUNTER: That's a really good question. So, I'll give you two answers and then absolutely up for discussion.

So, what we did was we published a list which I can certainly share with you all but it's de-identified. It's who is represented, the different agencies, the different providers. The reason we did that is because I can't have everybody asking them questions but the MAC is different.

So, let me talk to the Commissioner, and I see, with her support, we may be able to provide that just to you all, provide their names, knowing that you will keep that as just one of your MAC high-level documents because I do have individuals on there that are in similar positions to

yours at their employer, and I don't want their email to implode with everybody, but I think with the Commissioner's support, I can give the MAC the names.

COMMISSIONER STECKEL: I'm fine with it.

MS. HUNTER: We'll work through Sharley and through Dr. Partin and ensure that you all get the names, if you will just keep it under your hat, and as the MAC, you would have that additional information, if that's acceptable to you. And, Dr. Partin, will that work?

DR. PARTIN: Yes.

MS. HUNTER: Okay. Good question. Thank you, Susan. Other questions? Well, you know where I am if you need me. Thank you all.

DR. PARTIN: Thank you.

COMMISSIONER STECKEL: And the last item that I wanted to bring up was an issue that I put on the table at the Primary Care TAC.

We are going to start working with them to change the way we handle the payments, their PPS payments through the MCOs. The federal regs allow us to do certain directed payments, one of which is PPS payments and one of which is GME.

What happens now with an FQHC

is that the MCO pays them whatever their contacted amount is and, then, there is a reconciliation that we do the wraparound payment. And that process, as you can imagine, is both complicated, confusing for everybody in the equation and it's time-consuming and takes a lot of time to do that process.

FQHC's, unlike a lot of other providers, we are mandated to pay them their PPS rate and that's calculated, and I could bring the experts in and walk you through that reimbursement system, but it's an established reimbursement system.

So, what we are proposing is that Medicaid would require the MCOs to pay that PPS rate, no less than that PPS rate.

If the MCO wants to pay more, that's between the MCO and the FQHC, but, then, the FQHC is guaranteed to get their mandated payment, their PPS rate, and there's no need for either the FQHC or Medicaid to do a reconciliation and a wraparound payment.

Now, that's the proposal. The reason I brought it before the Primary Care TAC is I want to make sure we're listening to unintended consequences. It's one of those things where I think it's easy we just do this and I want to make sure

that when we just do this, something else doesn't happen as bad.

So, we're going to be working with the TAC. Again, this is a policy issue and one where we'll get their input and their discussion and thoughts as we move forward on implementing this. And we're looking to make it with the new contracts with the MCOs, so, 2020.

DR. PARTIN: I have a question. Will this apply to the rural health clinics as well?

COMMISSIONER STECKEL: Yes. Anybody that's paid a PPS rate, yes, ma'am.

DR. PARTIN: Right now Medicaid pays that wrap payment, but under your proposal, DMS would pay--excuse me. Sorry.

COMMISSIONER STECKEL: I think I know where you're going, and I feel for you because I've been coughing all day.

So, what would happen is we would raise--the actuarial rates for the MCO would go up to pay for those wrap payments. So, Medicaid would pay the MCOs. The MCOs would pay the entire PPS rate at least to the rural health center or the FQHC. Did that answer your question?

DR. PARTIN: Yes, that was the

question. So, basically, instead of paying the provider, you're just going to pay the MCO and, then, the MCO is going to pay the provider.

COMMISSIONER STECKEL: Correct. Correct, but we will determine that PPS rate. So, in the contract, it will say that the MCO has to pay the PPS rate established by DMS. And, then, once we establish that rate, then, that's what they will be required to pay the minimum of.

DR. PARTIN: So, are these going to be for clinics that already have established rates? Are those rates going to change?

COMMISSIONER STECKEL: All the FQHC's and rural health clinics have PPS rates and they do change, yes, ma'am. And, again, it's a methodology that's in both federal reg and state reg.

DR. PARTIN: Okay.

COMMISSIONER STECKEL: What it does is instead of having to do the payment from the MCO to the clinic and, then, us having to come in and say, okay, now what encounters were you paid for and which ones were you not and, then, what were you paid and now we'll come around and wrap it around and how much were you paid and how much is your PPS rate, it will eliminate all of that.

But, again, that's why I want to talk to the TAC and work it through with the TAC to make sure I'm not missing or we are not missing something that's obvious. There are a couple of issues, pregnancy issues that they've raised that we just need to work through.

But this was a perfect example of what I'm hoping we can all get to is that the TAC is a perfect group for me to have together to say, okay, we want to do this policy. We think it's going to be administratively easy to do. It's going to save you staff time, it's going to save us staff time. You'll still get your minimum payment that you would get in the wraparound. What are the issues? What are the problems? What are we not seeing in Medicaid?

DR. PARTIN: And I'm particularly interested because I own a rural health clinic. So, we'll get the payment that we're getting plus whatever the wrap would be.

COMMISSIONER STECKEL: Right, because if you think about it this way, the payment you're getting from the MCO is this. The wraparound payment is this. The whole amount is your PPS rate.

So, all I'm saying is we're

going to take that PPS rate, the whole rate that we are mandated to pay you and have it flow through the MCOs as one payment and, then, we wouldn't have all the administrative wraparound work that we have to do and that your clinic has to do.

DR. PARTIN: Right. Right.

COMMISSIONER STECKEL: I think everyone will be excited about it. I see Dave is over there.

MR. BOLT: We are very pleased with that discussion. In fact, we're having several meetings over the course of the next three weeks with membership about the issue. The parties recognize what we've had to do the last five years to make this work and I think we all realize the problems associated with the way it's set up now.

I'm feeling like Groundhog Day actually going back five years ago, but membership thus far is very happy with the process. We'd be glad to get this taken care of because we've got issues back July 1st of 2014 that's tearing them up and tearing us up.

DR. PARTIN: Thank you.

COMMISSIONER STECKEL: That is all I have, Madam Chairman. Any other questions?

DR. PARTIN: Any questions, any other questions?

MS. ROARK: I have some questions. I apologize I was late. This is my first time meeting you.

COMMISSIONER STECKEL: Well, welcome.

MS. ROARK: I have questions and concerns about all these copays. What if people don't have the copays? Are they turned away? How does that work?

COMMISSIONER STECKEL: Well, the copays, if you're under 100% of the Federal Poverty Level, the provider cannot deny your services.

If you're over 100% of the Federal Poverty Level, the provider has the right to deny you the service, and you'll have to find a provider that's willing to accept you if you do not pay your copay.

MS. ROARK: To make payments and that was with medically frail?

COMMISSIONER STECKEL: Medically frail is - and we'll be glad if you'd like to--we'll be glad to sit down and work you through

those kind of questions. Medicaid 101 is what I lovingly refer to it as. If you'd like, we'll be glad to do that and that might be a better way.

MS. ROARK: Yes, because I'm the voice and I represent a lot of people that's not here today and I have a lot of people that I network and reach out with and I'm on another board, the Behavioral Health, and I work with a lot of people with disabilities and I have a lot of questions and concerns.

And on a personal note, I have a daughter that's substance abuse and there's a lot of questions and concerns with people that can meet those deductibles and maybe they're in an emergency health crisis.

COMMISSIONER STECKEL: Well, there isn't a copay for a true emergency, is there?

MS. BATES: No.

COMMISSIONER STECKEL: So, if it's a--a true emergency defined by federal law is a reasonable person definition. So, there would not be a copay. Now, if you go into the emergency room with a cold, there will be a copay for that.

MS. ROARK: Yes, I understand that you need to have an emergency.

COMMISSIONER STECKEL: If you go in with a heart attack, then, there's no copay.

MS. ROARK: So, I was looking on here. Mental health and substance abuse inpatient is $50. And also I advocate for Casey's Law and a lot of parents want to get their children or loved ones in rehabs, that's a whole new ball game with getting that paid or getting help because we want to get our people off drugs.

COMMISSIONER STECKEL: Yes, ma'am.

MS. ROARK: And we have a crisis going on and I just hate to see someone suffer with--you know, a lot of people with mental health and substance abuse. I've partnered up with my--I'm from Jessamine County and I had a parent call me the other day crying and needing help. So, I need all the questions because I don't want to give them the wrong answers or mislead them.

COMMISSIONER STECKEL: We'd love to work with you, yes, ma'am.

MS. ROARK: Okay. Maybe I can speak to you after this.

COMMISSIONER STECKEL: That would be great. We would love it.

MS. ROARK: Thanks a lot.

COMMISSIONER STECKEL: Thank you.

DR. PARTIN: Reports from the TACs, and we'll be starting with Therapy Services, and I understand that Beth Ennis can't be with us today.

Next is Primary Care.

MR. BOLT: No report.

DR. PARTIN: Podiatry. Physician Services.

DR. GUPTA: We did not meet.

DR. McINTYRE: We didn't have a meeting in January. Our next meeting will be March 15th and we anticipate some recommendations to the MAC at that time.

DR. PARTIN: Okay. Thank you. Pharmacy.

MS. HUGHES: We got an email this morning from the Chair that since she was not going to be able to be here, she had some kind of meeting come up, she couldn't come.

MR. CARLE: Was that from Susie Francis?

MS. HUGHES: Yes. Thank you.

I couldn't think of her name.

DR. PARTIN: Optometry.

DR. COMPTON: Steve Compton for the Optometric TAC. We met last week, the 17th. Commissioner Steckel was there, Deputy Commissioner Bates and we had a discussion on the new directions that they wish the TACs to take, as well as how we can still solve our problems going forward, the MCO's.

Everyone was there. We had a quorum but we have no recommendations at this time, and our next meeting is in April.

DR. PARTIN: Thank you.

MR. CARLE: Steve, I had a question. What were some of your concerns with regards to the TAC issues?

DR. COMPTON: Some of the same things we've been talking about for a few years - payment processes, recoupments, different things like that. We've been encouraged to take more of a 30,000-foot view and get another forum to hash out those issues and I think we're going to get it worked out.

COMMISSIONER STECKEL: The Behavioral Health TAC kind of softened me up a little

bit.

MR. CARLE: Wait a second. Was Sheila involved?

COMMISSIONER STECKEL: She was the ringleader, no surprise to anybody in this room, but, then, the Optometric TAC kind of put the icing on the cake.

One of the issues that we heard loud and clear when I made my rounds to all the TACs is that there needs to be an opportunity for the claims discussions and more so than just Sharley sending out a note saying here is who you call at DMS, here is who you call in the MCOs.

So, actually, if you don't me sharing what we did in your committee.

DR. COMPTON: Not at all.

COMMISSIONER STECKEL: What we ended up doing, and I think it was a very eloquent solution, they had specific claims' issues they needed to talk to the MCOs about and Medicaid didn't need to be there.

So, we had the TAC meeting and we adjourned. Medicaid left and we gave them the room to have their meeting.

And, so, I think that that was

a good opportunity and kind of something that we may build on where we facilitate those types of discussions much like the Hospital Association has a monthly meeting with the MCOs.

I'm looking at you because the nursing homes also have asked for the same thing. So, I think that we may be kind of tweaking the way we do things to provide that opportunity.

MR. CARLE: That would be great. Since Dr. Compton brought it up, several of us did have concerns about the letter that you sent out on January 10th related to the Advisory Council for Medicaid Assistance, Medicaid Technical Advisory Committees.

And, so, I don't know if you feel it's appropriate to address that in this forum or to do it at another time because you stated some KRS regs which I really appreciated you putting in there but it's a difference of your interpretation of that versus somebody else's because, to my knowledge, it's not expressly written as to how you've gone about kind of giving us a prescription as to what you would like us to do.

And I think there is some, like you just said, there is some gray area in between

there and I'd like to find that happy medium where it's productive for you and your team and productive for all the TACs.

COMMISSIONER STECKEL: And I am fully supportive of that, yes, sir. And I agree. We've got parameters that are in the regs, but this is, you're right, my interpretation.

MR. CARLE: So, is the best way to do it here or----

COMMISSIONER STECKEL: No time like the present.

DR. PARTIN: Let's finish with the TAC reports and then do that because I had some questions on that as well.

Nursing Services did not meet. Intellectual and Developmental Disabilities.

MS. HUGHES: They did meet but they did not have any recommendations, but I just wanted to let you know they did meet.

DR. PARTIN: Okay. Thank you. Home Health.

MS. STEWART: We did meet in December and we have no recommendations at this time.

DR. PARTIN: Thank you. Nursing Home.

MS. HUGHES: I think you skipped Hospital.

MR. CARLE: Thank you, Sharley. I was going to ask her that but I'm in striking distance next to her.

DR. PARTIN: I just crossed it off.

MR. CARLE: Hey, now. I can get that sitting out there.

DR. PARTIN: Go ahead, Chris.

MR. CARLE: So, the Hospital TAC hasn't met since November 15th but we have not heard a response from our previous recommendations from November 15th. I don't know where it might be. I don't know if we've missed it because I've talked to other individuals and we've got a meeting scheduled for 2/26.

MS. HUGHES: Chris, I'm sorry. I'm pretty sure we sent those out but I will get back with you.

MR. CARLE: I've got quite a few others but I've never seen that one.

MS. HUGHES: Okay. Sorry.

MR. CARLE: That's quite all right.

DR. PARTIN: Nursing Home.

MR. TRUMBO: The Nursing Facility TAC met on January 8th, 2019 in Frankfort. After the TAC introductions and approval of the minutes, TAC Chairman Terry Skaggs gave a Chairman's Statement to the committee members and to the Department of Medicaid Services' personnel present.

In his statement, Chairman Skaggs said that this and future meetings, the TAC will be placing a different focus on topics included on the agenda.

Chairman Skaggs referenced Commissioner Steckel's comments to the MAC that the purpose of the TAC and the MAC meetings should be to deal with systemic issues affecting providers.

In the past, the Nursing Facility TAC has dealt with information system problems, billing issues, eligibility questions that can be addressed by Association staff members directly with the appropriate Medicaid, DCBS, DAIL and Guardianship representatives in the future rather than taking up time during the allocated TAC meetings.

The issues we discussed at our last meeting were issues of primary importance to

ensure nursing facility providers are able to provide quality care in the Commonwealth.

During the meeting, a graph was shared with DMS and attendees that showed the inflationary adjustments paid to nursing facility providers over the past ten years. The inflationary adjustment to the nursing facility price was far short of the inflationary adjustment paid by CMS for Medicare patients during the same ten-year time frame.

The inflationary rate of one-tenth of 1% paid to nursing facility providers over the past five years falls short of meeting labor and other direct and indirect patient costs.

Many providers across the state are in a state of crisis trying to retain quality employees while receiving only nominal inflationary increases over the past five years.

The TAC requests that a full inflationary adjustment to the price be made effective July 1, 2019.

The TAC also reported that in July, ‘18, the Association testified in a Medicaid Oversight Committee meeting that the nursing facility general and professional liability costs have

increased drastically over the past ten years.

I personally was at the table and testified that liability premium cost increases have crippled several of the facilities, resulting in two providers filing for bankruptcy protection and one not-for-profit facility dropping liability coverage entirely and going bare.

In an Association survey conducted in the Spring of 2018, freestanding facility providers that responded had a 47.5% year-over-year premium increase in 2018 compared to 2017. These tremendous cost increases cannot continue to be borne by nursing facility providers.

The TAC asked the Department for Medicaid Services for a response on nursing facility liability costs and for their support for an affidavit of merit.

Last, the Department was asked what will occur after the Patient-Driven Payment Model is implemented by CMS on October 1st of this year. Providers would prefer to continue using the existing RUG III system through September 30, 2020, as it would be less costly for both providers in the state combined to continue using the RUG III system rather than having to update RUG IV.

The next Nursing Facility TAC meeting has been scheduled for Tuesday, April 30, 2019. This concludes our report unless there are questions.

DR. PARTIN: Any questions? Thank you. Dental. Consumer Rights and Client Needs.

MS. BROWN: Thank you. I'm Miranda Brown, Vice-Chair of the Consumer Rights and Client Needs TAC. We met on December 17th and we did have a quorum.

DMS staff presented an update on the implementation of mandatory copays beginning in January. And the TAC members expressed concern that 1915(c) waiver recipients thought that this new policy would also apply to their coverage.

DMS staff clarified that it would not, but we feel more targeted communication to certain groups is still needed.

Another source of confusion is the close proximity of the 1115 waiver implementation which is scheduled to start on 4/1/19. Kentucky HEALTH includes a new copay component, of course, that would affect different populations than the current mandatory copay policy.

So, we anticipate that this will be confusing for all Medicaid recipients, but especially those who have been told that they are medically frail or should be determined medically frail once they complete the attestation process. These individuals have been told that they will not be required to pay premiums or copays.

We also asked for clarification on how an individual would know when they are receiving services at the same location or different locations which would affect the number of copays charged. For instance, an ambulatory care building may include multiple tenants providing different services under the same roof, whereas a federally qualified health center or a community mental health center is more likely to be a true one-stop-shop.

And whether the copay limit is based on physical location or a provider's billing ID makes a very big difference in how an individual would anticipate and budget for copays.

We had a lengthy discussion concerning the status of medically frail attestations that have been submitted to MCOs. Currently, no communication is being received by providers or recipients, leading many to believe their particular

attestation was denied.

While we understand that the medically frail category doesn't technically exist without the 1115 waiver in place, we think there should be a way to communicate whether a form has been received, processed, or conditionally approved/denied.

So, we suggest that DMS consider adding the medically frail status also to the Benefind self-service portal for recipients to view, in addition to the KyHealthNet portal that providers see.

We also discussed the public comment period for 1915(c) waivers. We understand that an advisory panel and sub-panels made up of stakeholders have been formed to look at targeted areas and work on implementation of the waivers; however, we note that DMS has decided not to release the names of participating stakeholders to protect their privacy.

We have some serious concerns about the transparency and accountability of this process. During our meeting, a representative from Protection & Advocacy stated that they are looking into the legality of a closed meeting process.

Finally, the Committee revisited our previous discussion regarding the need for TAC and MAC meetings to be ADA compliant. The committee asked DMS to review Title II of the Americans with Disabilities Act to determine if accommodations must be made for people with disabilities to participate in TAC and MAC meetings. One particular accommodation needed by a current TAC member is for interpreter services at the TAC meetings.

So, I'll end my report with our recommendations. We recommend that DMS make accommodations for all TAC and MAC members to be able to fully participate in TAC and MAC meetings including the cost of assistance and interpretation.

We wanted to clarify our previous recommendation to say that we recommend that all written communication that a Medicaid member receives in their requested language also be provided in English in addition to their requested language for the purpose of any consumer assistance that should be provided to them.

And we also wanted to clarify another previous recommendation to say that we would like all medically frail screening questions be asked

of Medicaid applicants and enrollees on the Benefind system or in a paper application.

Other recommendations are we recommend that the medically frail attestation form specifically include cognitive processes.

We recommend that the medically frail status display in the Benefind self-service portal.

We recommend that the terms "entity" and "place" be defined in the new copay regulation and policies to ensure that copays are accurately charged for same-day services.

We recommend that there be communication specifically for Medicaid recipients covered by a 1915(c) waiver that the new mandatory copay rule does not apply to them.

We recommend that there be clear communication to any Medicaid recipient who has self-attested as medically frail and/or has had a provider attestation completed, as to whether that attestation has been received, processed and what the final determination is.

And, finally, we recommend that DMS work with consumers to streamline the grievance and appeals process in the 1915(c) waivers and the

1115 waiver.

Our next meeting will be on February 19th. Thank you.

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

Children's Health.

MS. KALRA: Good morning. I'm Mahak Kalra, Co-Chair of the Children's Health TAC. We had our meeting on January 9th. Unfortunately, we did not have a quorum, so, therefore, we don't have recommendations.

DR. PARTIN: Thank you. And Behavioral Health.

DR. SCHUSTER: I appreciate the Commissioner saying we softened her up but didn't pummel her.

Good morning. I am Dr. Sheila Schuster, Chair of the Behavioral Health TAC. After welcoming the new representative nominated by NAMI KY, the Behavioral Health TAC was fully constituted at six members, all of whom were present at our January 9, 2019 TAC meeting, constituting a quorum.

Also in attendance were representatives from all five Medicaid MCOs, DMS staff including Commissioner Steckel, and many

members of the behavioral health community.

After approval of the newest TAC member and introductions of those present, Commissioner Steckel asked to address the TAC and those present. The Commissioner spoke for some time, announcing that she was "rebooting the TACs" to take them away from dealing with claims and other specific issues to focus on helping DMS to do a more efficient, better job of serving its recipients. She indicated that she wants the TACs and the MAC to focus on systemic changes, great ideas with more exploration needed and to leave claims and disputes with the MCOs for other venues.

The Commissioner stressed that the focus should be on new programs rather than on operational issues. She suggested that the TACs be proactive, rather than reactive, and that they not rehash policy decisions – like the copay decision – that have already been made.

The TAC members and others in the meeting asked a number of questions for clarification and further discussion and pushed back - I guess I should have said gently pushed back - on the notion that discussing the effect of policy decisions made by DMS – like instituting copays – was

not appropriate for the TAC agenda.

We felt that it was absolutely appropriate for the TAC agenda, expressing our strong belief that a function of the TAC being advisory to DMS was, indeed, to provide input about the effect of policy implementation on the Medicaid recipients.

In terms of the TACs being proactive rather than reactive, it was pointed out that it was difficult to be proactive if one did not know what policies or programs were being discussed at DMS so that input could be given before they were announced or rolled out, rather than reactively after the decisions had been made.

Ann Hollen of DMS noted that there were four behavioral health programs being discussed currently in DMS. She and I will meet to try to develop mechanisms for the TAC to be briefed on these program concepts in order to give the TAC the opportunity to give input to DMS before programs are rolled out. And Ann has already reached out to me and I appreciate that.

Concern was also noted about the requirement to move the TAC meetings from the Capitol Annex where our TAC meetings have always been held to the Cabinet building, where parking

is very difficult and the amount of walking required of participants is much greater.

A request has been made for written directions to the Public Health Conference Room where our TAC meeting is now scheduled to be held.

Getting back to the TAC agenda - and I have to point out that our TAC agenda over all the years that we've been in existence has never had items about claims or disputes with MCOs – we discussed the response from DMS to the recommendations that we made at that November MAC meeting, all of which were essentially negative with no explanation given.

We were given very brief updates on the 1115 waiver and the redesign of the 1915(c) waivers which have been on our agenda for many meetings.

The new policy for universal copays had only been in effect for nine days at the time of the TAC meeting, so, there was little hard data available about their effect.

Several examples of confusion or inappropriate imposition of copays were discussed, with DMS suggesting that they be contacted directly

with these examples so that they could be resolved.

There continues to be some confusion about residential SUD (substance use disorder) treatment services and whether the copay is daily or upon admission for the period of residential treatment.

This TAC has had a major focus on the systemic issue of the medically frail designation and process for more than two years. We again returned to this issue on the agenda with questions about implementation and communication between DMS, the MCOs, providers and Medicaid recipients about whom a decision is under consideration.

Stephanie Bates from DMS reported that clinician and self-attestations are coming in but there are no notifications of a decision because that category of medically frail doesn't exist until the 1115 waiver actually is implemented.

CMS has approved that all individuals who are given that designation will have it for at least one year, beginning on 4/1/19 or whenever the 1115 waiver is implemented.

Approximately two months prior

to that date, notices of eligibility will be sent out to recipients and those with the medically frail designation will be notified at that time. The MMIS page with the information will go live at that time and perhaps a little sooner.

There is no mechanism for communicating back to the clinician at this time. TAC members and others again pointed out that the ongoing lack of communication with clinicians continues to be very problematic.

We're taking valuable clinician time for them to fill out this attestation and then it goes into the black hole and there's a lot of anxiety out there among clinicians and among their patients about whether they're going to get that medically frail designation or not.

The advocates from the brain injury community shared that they are submitting information to DMS about the importance of maintaining therapy services as part of both the short-term and long-term ABI waivers. They are also working on legislation to require cognitive rehabilitation services for all individuals with brain injuries.

One of the TAC members had

requested that we have an agenda item on the loss of a 1915(c) waiver status if an individual was hospitalized or in residential treatment during the re-enrollment period. DMS staff was able to provide some clarity, including the fact that each of the waivers has a different annual re-enrollment date.

The problem seems to be that the individual – either a child or an adult – is not able to be reassessed while they are in the program and, thus, may lose their waiver slot if they miss the re-enrollment period.

We have two recommendations for the MAC at this time. Following on that discussion, we recommend that in the case of an individual who is in a 1915(c) waiver and who is currently hospitalized or is in a residential treatment program and where there is a reasonable assumption that the individual will be moving back into the community, that the assessment of the individual should be completed in the facility where the individual is housed in order to retain his/her waiver status before the waiver year expires.

Our second recommendation: In order to aid the MAC in fulfilling its statutory responsibility in KRS 205.550(3) to give advice

regarding how to further the participation of recipient members in the policy development and program administration of Medicaid, we recommend that all MAC meetings be made available via Facebook Live or a similar modality in order to educate recipients and providers, informing them about changes in policies and programs and encouraging their participation through organizations represented on the MAC and the TACs to give their input.

The next meeting of the Behavioral Health TAC will be on March 12, 2019 at 2:00 p.m. in the far reaches of the Public Health Conference Room where we have to park at the back forty and then hike up there.

I'm thinking of renting a bus to bring people actually from the annex. Don't be surprised, Commissioner, if we show up in a bus.

Thank you for providing this forum. I would ask since we've had so much discussion in our TAC about copay if the document that Stephanie Bates provided to you all might be available to the TACs through the TAC Chairs.

COMMISSIONER STECKEL: Yes.

DR. SCHUSTER: Thank you.

MS. HUGHES: I can send it to

them. It hasn't gone out electronically to the MAC y yet.

DR. SCHUSTER: Okay. Any questions?

DR. PARTIN: Any questions?

MS. STEWART: I have a question, not of her, though. Commissioner, do you plan to make it around to all the TAC meetings?

COMMISSIONER STECKEL: Yes, ma'am.

DR. PARTIN: Okay. Next on the agenda----

MS. STAFFORD: Madam Chairman, I have a request. On the TAC reports, is it possible for them to list those that are in attendance at those TAC meetings?

DR. PARTIN: Sure.

MS. STAFFORD: I'd like that.

DR. PARTIN: So, the request is on the TAC reports list who was present at the TAC meetings. You're just talking about the TAC members?

MS. STAFFORD: Yes, or who is present on the day that those----

DR. PARTIN: Sometimes that can be a lot of people.

MS. STAFFORD: Okay. Then I'll take the Chairman.

DR. PARTIN: Just the TAC members you want?

MS. STAFFORD: Yes.

DR. PARTIN: Thank you. So, next on the agenda is New Business and that is the memo that the Commissioner sent out regarding how the TACs will function.

And I would like to read into the record an email that I received from Beth Ennis who is the Chair of the Therapy TAC. She wasn't able to be here today, so, I will just read her email because she said she wanted the MAC to know.

So, she says: I just wanted the MAC to know that the Therapy TAC meeting this month was cancelled by the Cabinet without notice to us. One phone call to myself was attempted the day before the meeting which I could not answer as I was teaching.

No message was left and an email was sent to the TAC canceling our meeting. When I contacted Sharley as the email advised, I was told that the Commissioner was putting new rules in place and our meeting was canceled as we were out of

compliance with them.

When I asked for documentation of what these rules were, I was told that a letter was being finalized and would be sent within the next week.

While I understand that the Cabinet wanted an agenda ahead to be able to prepare, holidays and late editions prevented this from happening.

The Therapy TAC has worked tremendously hard since its formation to only bring systemic issues to the MAC and to solve other issues behind the scenes. We are frustrated at the handling of this situation, especially as many of our systemic concerns have not been addressed in the last four and a half years.

We will continue to work to advocate for access to services for the most vulnerable in our state and hope to continue to work well with the Cabinet but wanted to express our concerns about the current situation as we were unable to attend the meeting this week.

Thank you and I'm happy to address any questions, and it was signed Beth Ennis, Therapy TAC Chair.

So, having said that, we all received the memo that was written on the 10th of January regarding the format for the TACs. And as Chris alluded to just a little bit ago, some of this is based on opinion because there isn't anything in statute requiring many of these things.

Specifically, I have some concerns as far as requiring the TACs to meet at the--I don't know what that building is called.

MR. CARLE: CHR.

DR. PARTIN: CHR, and it isn't easy to access those rooms. I've been in those rooms before and it isn't easy.

Also, as far as a DMS representative to be required at the TAC meetings, that is not in the statute, and I would say that that should be up to the TAC as far as if they want a DMS representative at the meeting.

The meeting is public, so, certainly DMS can attend but I don't think that it's mandatory that a DMS representative be at the meeting.

COMMISSIONER STECKEL: Well, Madam Chair, if it's to help the Medicaid Program and DMS isn't there, what----

DR. PARTIN: I'm not saying that DMS can't be there. I'm just saying that it shouldn't be mandated that they be there.

COMMISSIONER STECKEL: You've lost me completely then.

DR. PARTIN: I'm just going through and then we can discuss.

COMMISSIONER STECKEL: Okay. I'm sorry.

DR. PARTIN: Another provision is that if the TACs don't submit their meetings for the year by February, then, they can't have a meeting for the rest of the year, and I think that that is kind of arbitrary because sometimes the meetings are scheduled if there's issues that have come up. And if there's not issues, then, there isn't a meeting.

And specifically I'm referring to the Nursing TAC because all of the members of the TAC have practices and work. And, so, if there aren't pressing issues that need to be discussed, then, a meeting isn't held because it's hard for people to get there.

But I understand that notice needs to be given, and I would say that a month's notice would be sufficient to get that posted if a

meeting was to occur.

MR. CARLE: On that point, your request, Commissioner, was that it's just scheduled for the year prior to that specific date. It doesn't have to be held to that schedule. You would just like to have a schedule in advance so you could possibly get your staff there.

COMMISSIONER STECKEL: Right. That's correct.

MS. HUGHES: And, Beth, just to clarify, the letter does not say that if you don't have your meeting scheduled by the 19th that you cannot have a meeting. It says that we would like that in order to ensure that DMS staff is available.

DR. PARTIN: It says if a TAC has not scheduled its meetings for 2019, they must be scheduled prior to February 15th.

MS. HUGHES: To ensure that the Department can staff the meetings appropriately.

DR. PARTIN: Right. So, I would interpret that to mean that if you didn't schedule the meetings for the year----

COMMISSIONER STECKEL: That was inartful wording and we apologize. The intent was to give us notice so that we could plan for it, prepare

for the rooms and make sure that we had staffing available.

DR. PARTIN: Okay. And, then, I think as far as what is discussed at a TAC meeting, the TACs should be able to discuss anything that they want to at their meeting. That doesn't mean that all of those things go into the recommendations, but I think that to limit what members can talk about is, well, I don't think it's a reasonable thing.

I think that they should be able to talk about whatever they want to talk about and certainly they should follow the agenda, but if somebody has an issue that they want to bring up, then, they should be able to discuss that.

MR. CARLE: I think what the Commissioner is trying to do is develop a continuous improvement of this process.

We as the MAC have evolved as well. In the past, we couldn't even get six people, not alone - I haven't counted how many we have here today.

So, we're kind of on a parallel path and I think what we need to do is work together on these. I guess this is kind of like the first stab at it, if you would, because it did bring a lot

of concern. Obviously Sheila has expressed that, the Hospital TAC has expressed that, Dr. Compton has, Dr. Partin has, but I don't think there's anything here that we can't work out in the guise of trying to improve what we're trying to do, and I applaud you for that.

Actually, today is National Compliment Day, so, I'd like to compliment you for that. Don't ask me how I know that. Somebody emailed it to me.

COMMISSIONER STECKEL: And I thank your willingness to work with me.

DR. CARLE: And, so, from a hospital perspective, we have our problems' list and the MCOs are all there. That's been very effective but we look at more global issues and I think that's what you're trying to get at.

However, there are some other issues that the TACs don't have the far-reaching experience that the Hospital TAC has. So, to your point before, I think you're going to have to tweak this within each of the TACs.

So, I don't know from the State's regulations how we can meet to discuss this, if it has to be an open forum or where we can have a

conference call related to this, but I think all of this can be worked out because I think some of it was different interpretation, different intent as we just talked about with regards to scheduling of meetings.

We've already taken care of that one, but the intent and its interpretation on somebody else's side was different than what it was intended to be.

So, I don't know how we approach that, but I don't think we have to sit here and negotiate it, so to speak, but I think it needs to be done.

And, again, I appreciate you setting this forth to give some guardrails, if you would, for the TACs so that they can be very productive and your staff can be very productive as well.

COMMISSIONER STECKEL: I would entertain a subcommittee of the MAC and we'll bring our folks together. We can go through it point by point; and where we think we can do that, I would love to.

And you're right. The Hospital TAC was the first TAC I went to. It's a very different TAC than the Behavioral Health TAC. And,

then, to see the Optometric TAC and the fact that you've got folks here, how can we maximize these folks that have taken time away from their practice to do some claims processing business, and it wasn't that but that kind of business.

So, attending each and every TAC gave me the ability to see the culture and the makeup of each of those TACs which was extremely helpful, but I would be glad to entertain a subcommittee of the MAC or anybody that would like to be on the call or come by the office.

MR. CARLE: Okay. Sheila?

DR. SCHUSTER: I think it's unfortunate that it was done the way it was done. If the Commissioner had come and observed and gotten those ideas and then called the TAC Chairs together. I think most of the TAC Chairs, and I'll speak for myself and not others, were caught completely off guard, didn't know this was in the works. The room was rearranged from the way we typically do it, I mean, just from that alone.

So, I would suggest that if you're going to have a subgroup working on this, that you have at least some of the TAC Chairs as part of that workgroup.

MR. CARLE: Well, again, history is a great teacher. So, let's not look backwards. Let's look forward, and I'd be willing to help and serve on that.

DR. PARTIN: Yes, I would, too.

MS. STEWART: I have a question. Since your letter came out, any email that I've sent to any of my contacts at the Department have not been responded to. Is that under the direction from you?

COMMISSIONER STECKEL: No, ma'am. No, ma'am. No, ma'am.

MS. STEWART: Okay, because that was the perception that I had from no response because I am the Chairman of the TAC that this is not your forum anymore.

COMMISSIONER STECKEL: No, ma'am.

MS. STEWART: Okay. Thank you.

COMMISSIONER STECKEL: If I ever were to give that instruction which I can't imagine, you would know that because I'm going to come talk to you. I just don't do business that way.

Now, admittedly, when the letter went out, I was frustrated. And I wish we had

kept the time records of my policy staff which should be doing policy work to solve the problems that you all were bringing, but, instead, they were working on TAC work, they were working on MAC work and it just was frustrating.

So, I apologize for the letter going out only in that hindsight is 20/20, not in anything about the intent of what that letter is.

So, Madam Chairman, will you send me the list of who all wants to participate and we'll schedule a call?

DR. PARTIN: Yes, and I would like to do that sooner rather than later because the TACs are going to be meeting and, so, I think we need to get that settled.

So, I will send an email to all of the MAC members and ask who would like to participate. And, Sharley, if you would send me the list of the Chairs of the TACs, I'm sure you've sent that to me before but I don't have it, and I'll send that to them, too. We can't get the committee too large but I think that some of us on the MAC are also Chairs for the TACs. So, that kind of helps that.

COMMISSIONER STECKEL: Thank you.

DR. PARTIN: Thank you. Anything else that anybody would like to bring up? Then I will entertain a motion to adjourn.

MR. PROCTOR: So moved.

MR. TRUMBO: Second.

DR. PARTIN: All in favor? Thank you.

MEETING ADJOURNED