CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

September 26, 2019
10:00 A.M.
Room 125
Capitol Annex
Frankfort, Kentucky

MEETING

APPEARANCES

Elizabeth Partin
CHAIR

Chris Carle
Steven Compton
Bryan Proctor
Susan Stewart
Jerry Roberts
Julie Spivey
Ashima Gupta
Sheila M. Currans
Ann-Taylor Morgan
Peggy Roark
Teresa Aldridge
John Dadds
Eric Wright
COUNCIL MEMBERS PRESENT

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AGENDA

AGENDA
(Continued)

DR. PARTIN: Good morning. Let's go ahead and get started.

First order of business, I would like to give special recognition to Dr. Susie Riley who was a member of this Council. On September 14, 2019, Dr. Riley passed away after a short battle with lung cancer.

Dr. Riley was a dedicated member of the Medicaid Advisory Council where she served for seven years. She was a strong advocate for patients and her dental profession.

What we didn't know about Dr. Riley was that she was a retired Lieutenant Colonel in the U.S. Army Reserves and we will miss her. And, so, I would just like to get on the record that we appreciate her service and that we will miss her. Thank you.

The next item, roll call.

MS. ALDRIDGE: Good morning. Just call their names out, Dr. Partin?

DR. PARTIN: Just call names and note that you are present or here.

(ROLL CALL)

DR. PARTIN: Thank you and we do have a quorum.

Next item is approval of minutes from the July meeting. Would somebody make a motion, please, to approve those minutes?

MR. CARLE: So moved.

MR. TRUMBO: Second.

DR. PARTIN: Any discussion? All in favor, say aye. Opposed? So moved. Thank you.

Next item on the agenda is a special presentation on the 2020 census and how it relates to Medicaid providers, and we are really pleased to have you come and talk to us and explain all this to us. So, thank you.

MS. CAULEY: Thank you. Very happy to be here.

My name is Kelli Cauley and I am a Partnership Specialist with the 2020 Census Bureau.

I have provided you with several handouts this morning, some that contain some very relevant information to this group in particular.

If you will look at the Counting For Dollars' information, the sheet that looks like this that has all the numbers down the

middle, on the very first line on that sheet, it talks about the amount of money that Kentucky receives directly to our Medicaid Program. That's over $7 billion per year coming to this state directly to this program to make sure that we can serve and provide services to those citizens of Kentucky and those that are benefitting from the services.

We have to have an accurate count of the individuals that are in the State of Kentucky to be able to disseminate the dollars appropriately toward the state.

We estimate that there are approximately 12,000 children in the State of Kentucky that were not counted in the last decennial census.

We know that most under-counted populations, this organization and Medicaid touches all but one of those populations. Our highest number of under-counted would be those age zero to four. The second number of under-counted will be ages five to nine. And if you think about those numbers specifically, we are talking about what affects us for the next ten years, decennial. So, those children have no dollars allotted to them for school

programs. They have no dollars allotted to them for other benefit programs that are in the State of Kentucky because they weren't counted.

And, so, we have to figure out a way to make sure that we get every child in the State of Kentucky counted so that we can appropriately get those dollars and to get them disseminated to the programs that they need.

Some of our other really low-counted numbers or low self-response rates would be those that are disabled, single moms, low income, adult black males and senior citizens, and this program obviously touches almost every one of those individuals and groups and organizations.

We do have a State Complete Count Committee that convened in May of last year. John Park from the Governor's Office is the Chair of that committee and they are actively working to determine and figure out ways to advertise or market or encourage self-response of all the individuals in the State of Kentucky to the census.

At the last meeting that we had back in August, one of the things that they recognized and decided to start investigating were ways that all of our CHFS programs could contribute

to making sure that we got an appropriate count of the individuals.

So, I know that they are going to be either imagining and coming up with ideas for our Medicaid Program in the State of Kentucky to implement, or I would ask on a better scale that before the October meeting that I receive some responses back from the group and Medicaid and how you would like to help us make sure we get an accurate count with your population, how we can encourage, whether it be messaging, whether it be something on flyers or information or emails or training or anything that we can do as an organization and as Medicaid representatives of the State of Kentucky to make sure that we get those low-counted populations counted and get self-responses from those groups.

What questions do you have for me?

DR. PARTIN: Any questions from the panel?

DR. GUPTA: Right now how are they counted? Are they just by surveys?

MS. CAULEY: Well, in the last decennial census which was 2010, it was paper surveys

is what went out and they could respond by phone at the time.

This year for the first time, well, 2020, for the first time, the census is going to allow an online option to respond. And, so, everyone with a mailable address will receive an invitation, a postcard invitation in the mail the second week of March inviting them to go online and complete their census survey.

It is ten questions total. None of them are invasive. We're asking race, sex, birth date, those types of things to make sure that we can get an accurate count of every person in your household whether they are related to you or not. And that's the important thing is that every person in the household needs to be determined, relation or no relation, and those questions are on there.

There are some prompters on the online option. It is available in twelve languages to toggle between. So, we do have some language options also in the online option.

The phone number to call in and respond is going to be at the bottom of that invitation. It is a 1-800 number. The phone has fifty-nine different languages available as far as

interpreters and being able to take that survey on the phone.

And, so, those are the two ways that we are most highly encouraging people to respond this year, and there will be an active, online, 24-hour-a-day map that provides percentage date of how many people in particular census tracts are responding so we can better determine how to target particular areas over the time that we are accessing the census.

Paper forms will not be sent out until the middle to end of April. We're hoping that they will respond either online or on the phone first. And as they complete their responses, that address will be taken off of the mail-out list for further outreach.

DR. GUPTA: I was just wondering, when they enroll in Medicaid, if they have to update every year. Could that be part of--no?

COMMISSIONER STECKEL: If I may, Madam Chair?

DR. PARTIN: Sure.

COMMISSIONER STECKEL: For Medicaid proper and eligibility, the census and its forecast doesn't have--if someone is eligible for

Medicaid, they will be made eligible for Medicaid whether they have been counted in a census.

If I could just make a recommendation that you all as providers maybe get a flyer or something from the Census Department asking your folks as they come in for appointments to have you filled out your census document and encouraging that because where it does impact dramatically are other block-granted programs.

So, early intervention, a lot of the child health programs. I'm not sure who all knows all of the whole list but even things like Highways and other programs, but there are a lot of programs that are impacted by the census that you all could help us with; and it may be as simple as just you all encouraging folks to complete the census forms as they come in to your offices.

But for Medicaid proper, if they're eligible, they will be made eligible for Medicaid regardless of whether they have completed or are counted in the census or not, but the census is critically important for the Commonwealth and the programs that we all serve and cross over.

MR. CARLE: So, Commissioner, I would suggest based on what you just said from at

least the hospital perspective that you work with the Kentucky Hospital Association, let them get that word out because we do have a pretty nice, a very robust communication machine with a checklist of what the pros are.

I'm sure you use the public libraries and other areas like that.

MS. CAULEY: Yes.

MR. CARLE: What about kiosks in certain areas like grocery stores or places like that?

MS. CAULEY: We are actually working with--not only do we have a State Complete Count Committee, but every county in the State of Kentucky have agreed to have their own County Complete Count Committee and those organizations are working in their communities directly to set up those types of activities, events and opportunities.

They also are printing print collateral for posters, signage, those types of things that you could potentially ask for to put up at your location or your office and those are all being done by the committees in the individual counties.

COMMISSIONER STECKEL: So, I

will give you my business card because then we can connect you not only with the Hospital Association but the Pharmacy Association, the Nursing Home Association, all of the folks represented by this group and, then, that will be a good outreach.

MS. CAULEY: Wonderful.

MR. CARLE: Another place you might use because a lot of people have it is with the cable company. They go there to pay their bill in cash.

MS. CAULEY: We do have a state partnership with Spectrum and I can't remember the name of the other cable company, but we do have state partnerships already developed with those organizations and we are actively working to do those things.

MR. CARLE: Great.

MS. CAULEY: But specifically Medicaid was brought up at the last State Complete Count Committee as something that we needed to attack and have a plan for. And, so, I wanted to bring information to you, and, again, emphasize how important it is to our Commonwealth that we get every individual counted because of those numbers.

If you look at the $675 billion

that is disseminated annually to the country from federal dollars and it comes down to that $15 billion for the State of Kentucky, if you break that down individually, it's a little bit over $2,000 per individual per year.

If we miss one household of five individuals that we didn't count, then, that's $10,000 per year not coming back to the state and their community. Over the course of ten years, that adds up big time. So, it's a huge impact for everyone.

COMMISSIONER STECKEL: Madam Chairman, she gave you some great information. I said I didn't know all the programs. She gave you all the programs that are impacted by this. So, as you can see, Title IV, the foster care, health care centers, school breakfast program. Thank you. This is a great list. I'm sorry I interrupted you.

MR. TRUMBO: I'm just curious what the outreach is for the homeless population. Are you trying to go to shelters?

MS. CAULEY: We are. We have lots of partnerships with those local organizations, the food banks, the shelters that are locally operated individually.

There also will be a two-night process right around April 1st, March 28th and 29th, I believe, where they send people out to the locations that have already been identified as places where homeless populate and sleep for the evening and they go out between the hours of 10 p.m. and 2 a.m. and do an actual physical count of the individuals that are on the streets in those locations.

So, we are already in the process of hiring and training the individuals that will be doing those counts.

MR. PROCTOR: So, a lot of times, they're wondering what is the benefit for them to fill this information out. So, is the information that's on the material you're sending out, is it going to show how it benefits them to fill this out?

MS. CAULEY: Unfortunately, it doesn't tell you the what's in it for me - it does not - which is where we need the local community individuals to provide that information and really encourage self-response.

We know the most accurate data that comes back to us is self-response data. We will get them counted probably. We're going to miss significant numbers, unfortunately, but we in some

ways will get you counted but it probably will not be accurate. How old you are, the populations that you may need, the sex, all types of things get missed when we have to go out and do manual counts of individuals so that it makes the information less valid.

DR. PARTIN: Any other questions?

MS. CAULEY: There are lots of digital collateral that is out there on the partnership pages. Let me recommend to you a website. 2020census.gov/partners has all kinds of information that you could print, send out. There's social media links for broadcasting social media, lots of resources available that can be shared and reviewed and all that type of stuff.

DR. PARTIN: Could you say that address again?

MS. CAULEY: Absolutely. 2020census.gov/partners, and thank you very much for your time today.

MS. HUGHES: Could you send me these documents electronically, please?

MS. CAULEY: Yes.

DR. PARTIN: Next up is Old

Business. We talked at the last meeting about KI-HIPP.

And as a follow-up, we were looking for information about actual cost savings to DMS from the program, projections for the future cost savings. Does DMS know how many Medicaid participants are working at jobs that provide health insurance to employees and DMS to provide before and after figures regarding cost and to provide some context.

COMMISSIONER STECKEL: Yes, ma'am, and we provided you this document. So, as of September 24th, we've had 185 members enrolled at a savings per month of $325 and an average savings per year of $3,903.

DR. PARTIN: This is completely voluntary, right?

COMMISSIONER STECKEL: Yes, ma'am.

DR. PARTIN: Commissioner, do you have any feedback from the people who have signed up for KI-HIPP as opposed to staying with Medicaid?

COMMISSIONER STECKEL: I do not, no, ma'am. There will be a survey done of their satisfaction but probably not for another year.

MR. CARLE: Commissioner, how do these numbers relate to the performance you had last year as far as the 185?

COMMISSIONER STECKEL: It's significantly higher, and we're hoping to get it into the thousands. We're working with employers including state government as an employer and trying to get the word out as much as we can to encourage this program.

DR. PARTIN: Okay. Thank you.

COMMISSIONER STECKEL: And we'll provide this at every MAC meeting.

DR. PARTIN: That would be great. That would be great and, then, when you do have the surveys to come out about the participant satisfaction.

I'm just wondering because some of the insurance plans that employers have are really good and some of them are not so good and Medicaid is really good. So, I'm just wondering what the feedback will be.

COMMISSIONER STECKEL: Well, and this is the best of both worlds for that beneficiary.

MR. WRIGHT: I know I can speak

to it as a parent. We've used the program before it changed its name officially to KI-HIPP. What it allows us for our daughters to do is to have more comprehensive care and allows us to be able to take advantage of premiums that are at high levels with a state employee when I was with JCPS through Anthem and, then, also now with U of L with their Anthem program.

It's a great benefit to those families who participate and I can see the actuarial cost savings to the State when it comes to particularly high-cost pharmacy or just related to some of their therapeutic needs. It's at a high cost, and, so, the primary insurance provider picks up those costs and saves Medicaid a substantial amount of money. That's my opinion.

COMMISSIONER STECKEL: Thank you. That's helpful.

DR. PARTIN: And I guess we're kind of getting into your report, aren't we, with the Old Business?

COMMISSIONER STECKEL: That'S fine.

DR. PARTIN: The next is an update on the 1115 Waiver.

COMMISSIONER STECKEL: The hearing date is October 11th, I believe, in the D.C. Circuit Court. So, we will know then. After that hearing date, what the Judge rules, if I were a betting person, I would bet money one or the other side is going to appeal whoever does not prevail and it will go to the Supreme Court.

We are still not anticipating making any changes related to Kentucky HEALTH until after 2020. That has not changed.

DR. PARTIN: So, I guess that will be on the next meeting, then, we'll know what the court decision was.

COMMISSIONER STECKEL: Correct, but I would be stunned if there's not an appeal, and I'm not often on these kind of things surprised but I could be.

DR. PARTIN: Probably not. And, then, we talked last meeting about the CMS plan to combine the Level 3 and 4 visits.

COMMISSIONER STECKEL: And I have to admit to a communication snafu. I was supposed to have a staff person that could address that here and she's not and it's my fault. I apologize but I guarantee you that we will have this

answer at the next meeting. I apologize.

DR. PARTIN: So, that leads us into your report.

COMMISSIONER STECKEL: Thank you, Madam Chairman. We are working with the Kentucky Department of Education on whether you call it free care or school-based services to open up the amount of services that can be paid for by Medicaid, thus, bring up state money for the school systems to provide more services for children that may not be Medicaid eligible but need services.

That is going extremely well. We are deep into what I lovingly refer to as the bureaucratic morass and that is the counting of the hours and who is doing what for Medicaid.

We will work through that. It's just a matter of getting it done with CMS and that should be starting--it already is starting but should be finalized and complete very, very soon, but that has been an extraordinary partnership with KDE, Medicaid and with the Cabinet on how we can open up services.

We're really excited about the potential with telehealth and behavioral health particularly with adolescents, not having to pull

them away from the school campus and being able to do some things there, maybe even continued partnership with FQHC's and rural health clinics that already do some of the services in the schools.

So, we think there's a lot of potential in that relationship to continue to expand what we do for children in the school setting while remaining linked to a primary care or case management relationship. Any questions about that?

I can't talk about the MCO contracts because that RFP is still in process. We're anticipating in November hopefully to have that resolved and public.

We are working on a variety of things that are financial but that are putting a large pool of money into the Commonwealth. One is on graduate medical education and indirect medical education.

We worked with the University of Louisville and University of Kentucky to not only expand the amount of money that they get with them paying the State share for graduate medical education and indirect medical education, but they also are financing the expansion of graduate medical education for sixteen community hospitals, and those hospitals

are Baptist Health Lexington, Madisonville, Hazard ARH, Jewish, Lake Cumberland, Methodist, Norton, Our Lady of Bellefonte, Pikeville, St. Joseph, St. Claire, St. Elizabeth, T.J. Samson and The Medical Center, in addition to UK and U of L.

So, we have finalized that. We've gotten approval from CMS and the dollars should start flowing in the next sixty days.

So, that will enable them to increase the number of residents, to increase the number of slots that they have where they can do training in the community and at the two universities. So, we're very excited about that.

It's about $61 million for the sixteen hospitals and, then, the IME is significantly more.

We're also - and bear with me if I'm getting in the weeds - but on the final managed care reg from CMS, they told states that we can no longer direct payments. So, we can't say to a managed care company, you have to pay this provider this amount of money as a supplemental payment.

So, we're having to realign all of that so that we can maximize our resources and we are doing that. The directed payment methodology, we

have gotten approval from CMS for the two universities. And I say I'm not often surprised. I was blown away that they approved what we submitted to them. It was legitimate, it was correct and it was proper. I thought OMB would put a stop to it because it put into the Commonwealth about $300 million more than what I thought they would approve. So, we now have that done on the U of L/UK side.

We are working very, very closely with the Hospital Association. We have a meeting every week where we walk through not only their provider-specific tax that passed the Legislature last year but their directed payment component so that all of that is aligned and approved.

So, that work is going extremely well and we've got one piece, the fee-for-service piece approved from CMS. So, we're working on the managed care piece which, of course, is the biggest piece of it all. And to say that that relationship and that collaboration is going well, I think your hospitals would say the same thing, but it is a very good partnership that we're getting a lot of good work done, and not just on that.

Other things come up that we're

able to follow up on, but we should get that done in the next sixty to ninety days.

Any questions or any other issue you'd like me to address?

DR. PARTIN: The money that's going into the hospitals for the residency programs, is that a special allotment coming from CMS?

COMMISSIONER STECKEL: It's a special allotment. So, the universities are paying the State share and the feds are, of course, putting up their share and, then, we pay them through Medicaid.

DR. PARTIN: Okay. So, the universities are paying. Are the other hospitals going to have to pay?

COMMISSIONER STECKEL: No, ma'am.

DR. PARTIN: Just the universities.

COMMISSIONER STECKEL: And they didn't have to. So, I thank UK and U of L but they didn't have to. Now, it's in their best interest because it helps them with their training program, too, but this is an example of where we sat down and figured out what's the best for the system whole and

how can we best fund it. And UK and U of L stepped up to the plate and they benefitted. The other hospitals benefitted and Medicaid is benefitting from having trained providers.

DR. ROBERTS: Was there a framework or guidelines on primary care versus specialties as far as the growth slots?

COMMISSIONER STECKEL: I don't know the answer to that because that would be done out of the Council of Graduate Medical Education and the federal government. I thought I had to know calculus to do Medicaid reimbursement, but residency slots, it's amazing how complicated that is.

DR. ROBERTS: I work at Lake Cumberland and they started their internal medicine and family medicine programs about four years ago, and recruiting internal medicine physicians to rural areas is a challenge we all experience.

And as the graduates from these programs are starting to stick around, I mean, a small town like ours is really reaping the benefits of this already. As the program increases in size, we would love to see that stick around even more.

COMMISSIONER STECKEL: Well, you all are getting about $670,000 more in GME over

what you're currently getting. And that was the idea of why we wanted to expand it beyond just the universities is the more we can get people in to the communities, the more they affiliate and stay. So, I'm glad to see that that's happening. Excellent.

DR. PARTIN: Any other questions for the Commissioner? Thank you.

MS. HUGHES: Commissioner, one other thing you may want to mention that I just thought of was open enrollment dates of November 4th through December 13th.

COMMISSIONER STECKEL: Thank you.

MS. HUGHES: And there's material out on the website that's gone out to the members.

COMMISSIONER STECKEL: Thank you, Sharley. That's exactly right.

And let me also introduce Dr. Theriot. Judy Theriot is our new Medical Director, not so new anymore, but this is the first time she's been able to be here.

She will be talking to you all about urine drug screening testing later on in the agenda, but she is a pediatrician out of the

University of Louisville, has worked with the Children With Special Health Care Needs' clinics, is extremely knowledgeable particularly around children. She still practices on Fridays. So, she stays up on it but we are thrilled to have her on board and very excited about how much she has already contributed and how much she will continue to contribute.

DR. THERIOT: Nice to meet you all.

DR. PARTIN: Welcome. So, this leads us to the TAC reports and Therapy is up first.

DR. ENNIS: Good morning. I'm Beth Ennis, the Chair of the Therapy TAC. We met. I've missed a few meetings. So, we met in May, July and September. And per the information we got about open meetings and our video conference, we've had a quorum at all of them.

We've been working through a couple of things that I think are going really well. We did make a recommendation to the Cabinet about the potential RFP that they were thinking about for credentialing and the use of CAQH versus an external organization since most of the MCOs were using that already and it might streamline the process and save the Cabinet some money. So, we forwarded that

information on.

And, then, we're working through some other issues. We've been very pleased that the MCOs have been in attendance and been very helpful at working through process issues.

I think our biggest one that we're trying to solve right now is how to make sure that the fee schedule is updated in a timely manner every year as the changes go through but we have some suggestions coming forward for that as well.

We have no direct recommendations and that's all I've got.

DR. PARTIN: Have you had any feedback about using CAQH?

DR. ENNIS: Only that most providers use it already anyway. And, so, it would certainly make it easier on the provider side.

We heard from the MCOs that a lot of them are using it anyway already. And between the provider portal information that Medicare collects the information they specifically need in CAQH, it seems to do everything. And, so, that was our suggestion and it has to be updated every ninety days anyway.

DR. PARTIN: Right. It would

be easier for me for sure. Thank you. Primary Care.

MS. HUGHES: Primary Care met yesterday. Unfortunately, they said they did not have anybody that was able to come today to the meeting but they do not have any recommendations.

DR. PARTIN: Okay. Podiatry. Physician Services.

DR. McINTYRE: Good morning. I'm Dr. McIntyre. I'm the Vice-Chair of the Physician TAC.

We met September 6th. We did have a quorum. We discussed principally telemedicine, managed care organization updates were given with all five managed care organizations represented, and public health trends. We have no recommendations. Any questions?

DR. PARTIN: Thank you. Pharmacy.

DR. FRANCIS: Hi. I'm Suzi Francis, Chair of the Pharmacy TAC. We did meet on September 17th. We had all five members present.

We had a productive discussion with DMS Pharmacy Department led by Jessin Joseph and the MCO Pharmacy Directors about various topics. Our minutes will be coming shortly when they're ready but

some notable items. I had five notable items that we discussed. No formal recommendations but five items.

So, the Kentucky Pharmacists Association is promoting the communication of the Kentucky HEALTH website to pharmacists so that pharmacists not only know how to use the website and get members' ID numbers from there but also to determine if they met their quarterly out-of-pocket copays and help communicate that.

Dr. Joseph also did say that if there's any inconsistencies in what the website displays to let him know and they'll work through that.

And, then, DMS continues to research the Senate Bill 5 data transparency issue, and Jessin was meeting with pharmacists across the state about reimbursement rates. In the future, we will probably work with DMS to determine the needed appropriate costs and reimbursement for dispensing fees in that area.

So, third, each MCO provided an update of their pharmacy-related items both operational and clinical. Aetna Better Health of Kentucky reported that they will present the results of their CPESN pilot project which is a clinical

project to help improve member outcomes, working with pharmacists across the state. They currently have six pharmacies in Western Kentucky and they're expanding to fifteen additional pharmacies throughout the state and they're going to present at our January Pharmacy TAC meeting about some of their results.

And we did discuss the 340B policy. There have been some pharmacy comments made from different pharmacy associations to the Department and we just noted that that was up for comment until October 3rd, and I asked Jessin to please consider some of the pharmacy comments that are being submitted, too, and he explained some of the reasonings they had on their 340B policy draft.

And, then, lastly, our action item that we took away from this meeting was the Pharmacy TAC members are going to review the DMS quality strategy and we're going to discuss opportunities for pharmacists to assist in achieving the quality goals outlined in the strategy at the November meeting, and that's all. Do you have any questions?

MR. CARLE: Yes. Suzi, could you go over just a little bit more, give a little bit more detail on the 340B discussion?

DR. FRANCIS: Yes. So, Jessin explained - and please correct me if I'm wrong - I know the Commissioner wasn't able to make our meeting this time - but Jessin explained that DMS hasn't had a 340B policy, and, so, they needed to enact one and this was their attempt to help hospitals, pharmacies and things to be able to use contract pharmacies.

I'm probably way over-simplifying that, and some concerns that I have in working in a health system and very dependent on some of our pharmacy services, our clinical services that we have to get is the ability to really use the 340B program and the contract pharmacies, and we want to make sure that we're not limited by the 30-mile radius with contract pharmacies in that sense.

There is going to be, if there hasn't been yet, a KSHP, Kentucky Society of Health-System Pharmacists' letter to probably comment. There was an Ephraim McDowell letter submitted for comment from their hospital.

COMMISSIONER STECKEL: This is the federal government concern that the 340B Program is getting, as they say, out of control.

So, part of it is we're having to respond to the feds saying to us, you need to

tighten down your 340B. So, we're trying to do that in response to what they're asking us to do.

The other thing, too, is that we're not getting rebates on drugs that we should be getting rebates on, or because they're 340B, we may claim a rebate and we're going to have to pay that back eventually. So, we want to make sure----

DR. FRANCIS: That's exactly right. Relying on the--you know, I from my local St. Elizabeth pharmacy can determine what drugs were eligible for rebate and what drugs were not with 340B pricing, but how do I rely on contract pharmacies to ensure that modifier is put in there, to the national contract pharmacies' care, if that's put in there or not?

COMMISSIONER STECKEL: And no surprise to anybody, and I have a lot of good friends that are lawyers, but there are now law firms that are contracting to look for this issue.

So, it is not the desire of the Department to limit access to 340B where it's appropriate in compliance with the law. These programs have been extremely beneficial. You think of the cancer centers, the other services that they are participating in, but we want to do it right. We

want to be careful about it and we want to make sure that we're accounting for rebates accurately.

So, this is all part and partial of that, and the comments and the suggestions and the help that we're getting from everyone, the hospitals and the pharmacists is helping us kind of hone this policy down, but understand that Congress, if their time wasn't being taken up on some other issues, they probably would be dealing with 340B.

MR. CARLE: Do you have a time line as to when you're going to have the ability to make that decision and get the clarification that you need? Obviously you need some, as you just mentioned, from the feds, so, I won't hold you to it; but as you've indicated, you both indicated there's millions of dollars on the table here and it affects everybody in the state.

COMMISSIONER STECKEL: This will probably be an evolving situation in that we've put the first phase in. We may modify that and, then, we may modify that after but it will be that type of a situation.

MR. CARLE: So, maybe one thing we could do is have that as a standing item of Old Business to review moving forward.

DR. PARTIN: Sure.

MR. CARLE: Is that okay with you?

COMMISSIONER STECKEL: That'S fine.

DR. FRANCIS: And Jessin was meeting with some pharmacies across the state and continuing to look into that, I believe. I would love to have him up at St. Elizabeth to see how it affects us, but I think there's just a lot to consider if national contract pharmacies are going to comply with this or not. It's a big concern for the pharmacy.

COMMISSIONER STECKEL: And the one thing I cannot afford is to have a potential recoupment hanging over my head. Particularly knowing that there are law firms out there that are starting to develop practices around this effort, that's the last thing I need and the last thing any of us need for our budgets.

So, we're trying to be very careful and thoughtful in working with both the hospitals and the pharmacies to make sure that we're doing the right thing for both the program and for the beneficiaries.

MR. CARLE: Are the MCOs recouping it?

COMMISSIONER STECKEL: They are to a degree, yes, and we're working with the MCOs.

MR. CARLE: Just looking over at my resident expert over there.

COMMISSIONER STECKEL: But we'll have Jessin at the next meeting and he can talk in very detail about this, but the MCOs are involved in this also.

DR. FRANCIS: And if you read the transcript from our pharmacy meeting, you can hear Jessin's direct comments, too, on the why behind it.

COMMISSIONER STECKEL: And be able to sleep well afterwards.

MR. CARLE: I was going to say, Suzi, on my way home, I'm going to have that dictated.

DR. FRANCIS: It's not available on podcast yet.

DR. PARTIN: Thank you. Optometry.

DR. COMPTON: Steve Compton, the Optometric TAC.

We met on August 15th. We had a quorum. We have had one member resign, so, we will be replacing her.

We did have a discussion about Aetna Better Health's incentive that they're offering their diabetic patients to have an annual dilated eye exam and we had some questions about that that should get answered at our next TAC meeting.

We have no recommendations and we meet again November 7th.

DR. PARTIN: Thank you. Nursing did not meet. Intellectual and Developmental Disabilities.

MS. HUGHES: They did meet but I guess no one is here.

DR. PARTIN: Okay. Hospital Care.

MR. RANALLO: Hi. I'm Russ Ranallo, Vice-President of Finance at Owensboro Health, Chair of the Hospital TAC.

The Hospital TAC, we met on August 27th. We had a quorum. I don't have any formal recommendations but I wanted to go through some of the things that we discussed.

One of the items we discussed

again was sepsis. This has been an ongoing theme through several of our meetings. Dr. Theriot and representatives from St. Elizabeth, as well as KHA and myself met on July 2nd to talk about the change in the sepsis definition.

This goes back to Dr. Liu where one of the MCOs came and asked for utilization management, could they change the sepsis definition from what CMS uses for coding to what was put out in a JAM article and is being adopted by some insurance companies. It essentially makes it harder for hospitals to code sepsis and it ends up being a reduction in DRG payments.

The Cabinet with Dr. Liu were leaning towards adopting Sepsis-3 versus Sepsis-2. Sepsis-2 is the way CMS codes it.

We had a meeting on July 2nd to discuss it and one of the outstanding questions was, is it just for utilization management or is it also going to be applied to DRG coding?

And we explained the challenges with that and having to be able to take a subset of the population and code it one way versus coding it another and the results that it shows to everybody in coding and billing and quality and we asked for an

update from the Cabinet and they're still reviewing it. So, we're not going to make any formal recommendations until we try to work it out all the way through.

As was talked about just a minute ago, Dr. Joseph also came to the Hospital TAC about 340B and we had more people there for this topic than we've had from the hospital side at the TAC in a long time.

As they stated, the policy was put out there to make sure that duplicate discounts aren't incurred and it was really a safety net and a mandate by the feds.

And, so, it's designed to stop the overlapping of the duplicate discounts. What we did clarify, it doesn't apply to hospital claims. It applies to 1,500 physician claims and it applies to contract pharmacies, but you had hospitals that have contract pharmacies that utilize the 340B Program for them and they expressed some concern.

They've expressed some concern on the time frame, whether or not the IT, the information systems will be able to be fixed for the January 1 date.

They also said that the whole

purpose is to put a billing indicator on the bill. Most of the 340B are identified after the fact and it's done in arrears, and, so, there was concern about compliance there and whether the contract pharmacies really could comply.

There was also concern about the 30-mile rule, especially within the rural hospitals where they have specialty pharmacies that aren't in that 30-mile distance but are outside that 30-mile distance and not being able to meet that.

Dr. Joseph was very gracious of his time and fielded a lot of questions and had discussion and encouraged the hospitals to send in their comments and we did as well and those comments will be taken until October 3rd.

We had an update on HB 320, the Hospital Rate Improvement Program, and I will echo what Commissioner Steckel said. It has been a very collaborative and great process and we appreciate all the hard work that they have put into that important initiative for the hospitals.

An update on the prior authorization issue. We had an issue that I brought here before or reported on here before where a hospital is given an authorization for a surgical

procedure; and in the surgery, the code that was authorized ends up being different. We were given twenty-four hours to get an update of that code from the MCOs and we were getting significant denials. Hospitals were getting significant denials because it's not possible.

We had discussions with the Cabinet and with the MCOs and the Cabinet has communicated to all the MCOs that the minimum days to have that allowed for an update is seven calendar days.

So, that gives us opportunity to put processes in to do those updates on care that they approved, utilization they approved and it's not a technical denial anymore for something that is medically necessary.

I reported on a call I had with Dr. Joseph about NDCs. It's older and it goes back years where we've tried to ask the Cabinet about looking at a model to allow the hospitals not to report NDCs on the bill. Maine has exempted their hospitals from reporting NDCs. They got it approved by CMS.

MR. CARLE: Russ, a lot of people don't know what NDCs are.

MR. RANALLO: National Drug Codes. You have to submit a code on your bill for a drug that you're billing and it's based on manufacturer, package size. It's very complicated. It's not anything that--we have to bar code scan it. We can't have a compendium. We can't have a look-up list because there are so many variables in it and it's very complicated.

We get denials on it because no one can do it right. If anybody is telling you they can do it right and 100%, they're wrong. They've got errors.

And, so, Maine gave their hospitals some relief from billing these NDCs. It takes a lot of maintenance on the IT side. We get, again, payment denials for things when we make errors, and he was receptive to look at that and have discussions with us.

But he also explained to the TAC that each MCO has their own Preferred Drug List. So, if I bill and I'm getting NDC denials from certain MCOs and not other MCOs, he said that the possible reason for that is that there's a Preferred Drug List that's been approved for WellCare and a different one for Aetna and a different one for

Passport. And, so, that NDC that may be in the other one's preferred one may not be on the WellCare one or the Aetna one or the Passport one and may get denied by that certain MCO.

So, I asked the hospitals to look at their data because that's something that we want to dive into. I don't think it's fair to have multiple NDC lists or a Preferred Drug List to have denials on things that we don't really control.

MR. CARLE: Let me interrupt you just for a second. Commissioner, are you allowed to let us know if that issue has been addressed in the RFP moving forward with the MCOs?

COMMISSIONER STECKEL: I don't know the answer to that question. I could if it's in the contract but I don't know the answer to that question whether it is or not.

MR. CARLE: It might be difficult to get a consistent formulary across the board.

DR. FRANCIS: Pharmacies are subjected to the same thing. We just have to make sure that we carry the NDC that that MCO covers.

MR. RANALLO: And that NDC may cost more, right, the hospital versus when you're

talking about multiple discounts, you're talking about GPOs, and they may have different costs on the different drug and having to know that, know that for a patient that's in the hospital is an Aetna patient versus a Passport patient. So, that Passport patient, I have to give this drug and this NDC versus the same drug and another NDC would be quite challenging, almost not doable from the hospital side.

COMMISSIONER STECKEL: The NDC is the identifier of that drug. So, it would be whether you have this NDC or another NDC. The NDC could be a very long number. As Russ said, it's going to be the manufacturer, the size, the bottle, the date and all of that, but it's critically important that we maintain the NDCs.

Now, the issue of the common formulary, I know that we are looking at that. That will be part of the report that we're doing when we replicate the West Virginia report that the Legislature has asked us to do of whether it would be cost effective to pull pharmacy out of managed care and have Medicaid manage the pharmacy program, and that is one issue that I know Dr. Joseph is looking at specifically.

MR. RANALLO: And at the end of the day, it's we're getting denials on a drug that we gave that was medically necessary because the NDC doesn't match their list and that's what I have a problem with, I guess, is that we're trying to do the best thing we can and we've got an NDC on there, but just because it's not on WellCare's list, I've got to manage that and nobody knew it from the hospital side. To a hospital, there was nobody on the TAC that knew that could be the potential cause of why we're seeing some NDC denials.

We talked about the IPRO appeal reviews. The IPRO is the independent organization if we get a denial from the MCO that the providers can go to when they disagree with.

We brought some examples to the Cabinet about--there's clinical validations. So, they look at clinical validations. So, a patient comes in and an example I gave at the TAC meeting was there was a NICU baby and the baby was coded with respiratory distress syndrome. The MCO disagreed based on the medical record documentation and the hospital appealed it to the IPRO.

The IPRO had--what was said in the letter was a billing specialist did the review

from the IPRO. From CMS' perspective with RACs and audits and those things, billers and coders can't do a clinical validation. They're not qualified to. There's no biller that I know that can look at a medical record and say that baby had respiratory distress syndrome or not.

So, we expect a provider to do that appeal or to review our appeal and it didn't happen and there were numerous cases that we gave to the Cabinet to review and asked them to look at their contract because that case is going to go to administrative hearing where attorney fees are going to be involved and it's going to go further.

So, to have somebody that's not qualified at that level is not doing a service to the Cabinet and not doing a service to the provider as well or whoever is appealing it, whether it's the MCO or the provider. So, we had that discussion and asked them to review that and report back.

The KI-HIPP, we had a presentation from the Cabinet as well and we also talked about the 2020 DSH update and we had a small discussion again on the outside consultant charge audits and that may come back in a further meeting.

Our next meeting is October

22nd.

DR. PARTIN: Just to clarify for myself because I wasn't familiar with NDCs, is that basically the formulary and you're saying that they won't approve the drug because it's not on their formulary?

MR. RANALLO: As I understand it, and I'm not a 100% expert, they have a Preferred Drug List that's been approved for WellCare. And under that Preferred Drug List, there are certain drugs with certain NDCs, so, certain manufacturers that they may have and those may vary. They're not the same for all the MCOs.

DR. PARTIN: So, it can be the same drug with a different NDC?

MR. RANALLO: Yes. Each manufacturer, if I have Drug A and three manufacturers make it, there's a different NDC for each one and, then, the NDC is different based on the dosage, based on pill or liquid. I mean, there's a lot of factors to go into that NDC.

That's why it's very difficult for us to get the right NDC on the bill sometimes because there's so many different factors. If you're not bar code scanning it at the time that you give

it, it's almost impossible.

DR. PARTIN: Would it be at the time that you purchase it?

MR. RANALLO: We get the NDC from the drug at the time we purchase it, but, then, we have to load that into the system because we have different NDCs. Even within the same manufacturer, you have different NDCs and we have to have the right NDC that we gave to that patient.

DR. PARTIN: So, it has to do with the deal that the MCO made with the drug company?

MR. RANALLO: It's the list that they've gotten approved by DMS, as I understand it, and I don't know what they've done with the drug company. I can't tell you.

COMMISSIONER STECKEL: It's a formulary issue. The NDCs--and Suzi may be able to address this. NDCs are these numbers that get longer and longer and longer as time goes by but they could basically identify--if we were to look at an NDC, if I were to go in to a pharmacy and pull an NDC, I'm going to know the manufacturer, what the drug is, what the dosage is, what the type of administration it is and the package size. So, it helps us

understand what all of that is.

Now, what is happening, if I understand correctly, is that Aetna may have a formulary that covers Drug A with an NDC that there could be ten NDCs that actually cover that drug; but, then, WellCare has a formulary that covers Drug B - same drug, same indicator - but there are ten different NDCs that cover that drug.

So, what it is, it really is tied to the formulary; that what's happening is that they're running the NDC on Drug A, and because one of the MCOs only allows Drug B on their formulary, it's kicking it out as not allowed.

DR. PARTIN: But you're saying Drug A and B are the same drug.

DR. FRANCIS: It's the same name but it's a different National Drug Code identifier, so, the numbers don't match. So, even if you were to say we cover flu shots, you may only cover five different brands of flu shots instead of another company covering a different five manufacturers of the flu shots, and it's a way to make sure things are safe is to bar code NDCs.

DR. SPIVEY: It can also vary with dosage forms. So, if you have a tablet that you

just swallow versus a tablet that dissolves in the mouth, they may be the same drug, but WellCare only covers the one that you swallow where the other ones might cover the one that dissolves in your mouth.

MR. RANALLO: And we were seeing NDC denials and we didn't know why and we were spinning our wheels because the NDC that we see looks good to us but it's being denied by the MCO, and the MCO says, well, we don't cover that.

And, so, the discussion that we had with Dr. Joseph on NDCs just in general kind of evolved into, well, we're seeing these denials and he started to talk to us about why we might be seeing them and what we need to do to look at how to drive into it a little bit more.

COMMISSIONER STECKEL: So, the core issue is the formulary, that we allow each MCO to choose their own formulary within the federal law about all the rebates and everything like that. And, so, the formularies differ.

Now, the NDCs are complications in and of themselves just because they do track so many things, but the real core issue is that formulary differential.

MS. CURRANS: But when you

started your conversation about them, your suggestion was that we look at Maine because they were able----

MR. RANALLO: So, Kentucky pays for drugs less than cost. So, Maine went to CMS and said because we're paying the hospitals less than their costs for drugs, we want to exempt them from doing NDCs and CMS said okay. So, that was the Maine model and that one goes back several years.

We had a workgroup actually but there's been a lot of changes in administration and in the Commissioner position and it was something that I've been on the TAC for a while and I wanted to bring back up, especially I heard great things about Dr. Joseph, and have that discussion with somebody that would maybe understand it.

I'd like to continue to have that discussion because I think it's maybe a viable solution to the problem.

COMMISSIONER STECKEL: Thank you. And this may be an appropriate time to bring together the Hospital TAC and the Pharmacy TAC to talk about this together. So, we'll take it--I'm sorry. I'm inappropriate.

DR. PARTIN: No, no.

MR. RANALLO: That's great.

DR. PARTIN: Thank you.

DR. McINTYRE: I serve also as the Vice-Chairman of the Fee-for-Service Pharmacy & Therapeutics Advisory Committee and have been on the committee for four years and I'm just reinforcing the Commissioner's comments that our committee only makes recommendations in the fee-for-service program and on that, only on outpatient medications, and each MCO repeats that process in their own way of determining what's on their formulary.

Also, incidentally, we're not allowed to disapprove any medications that are part of the Federal Drug Rebate Program. We can only recommend them as preferred, preferred with clinical criteria or non-preferred.

DR. PARTIN: Thank you for that clarification.

Home Health.

MS. STEWART: The Home Health TAC met. We have no recommendations and we meet again in October.

DR. PARTIN: Nursing Home.

MR. TRUMBO: The Nursing Home TAC did not meet. The next TAC meeting is scheduled for October 8th, and the primary focus for providers

now is the new Patient-Directed Payment Model, PDPM, which is effective 10/1/19.

DR. PARTIN: Thank you. Dental.

DR. SCHULER: Good morning. My name is Dr. Phil Schuler. I'm the Dental TAC representative to the MAC.

We've met twice. We met May 15th and August 14th. We had quorums present at both meetings.

At the May 15th meeting, we were discussing some of the issues we're having with poor oral hygiene and poor preventive maintenance of compliance with the patients that are in orthodontic care and we were having reports of pretty severe amounts of decay being present on the teeth through the process of orthodontics when they weren't seeing their primary care dentist for their needed maintenance.

So, there's really no national policy to follow on that. There's no national governing body. So, the KDA put together a workgroup that consisted of U of L, UK, a private orthodontist, Dr. Caudill was on it, Dr. Heather Wise who is a pediatric dentist on the TAC, and they worked through

to create some recommendations from the KDA to the TAC.

The problem with oral hygiene in orthodontic patients, it's not just related to Medicaid, but it's exacerbated in Medicaid because of the lack of compliance that we see and the issue with missed appointments is a big challenge for that particular population.

So, the KDA workgroup's recommendation for both referring dentists and orthodontists are always to enforce and encourage proper oral hygiene during treatment; enforce and encourage regular visits by the patients to their pediatric or general dentists for recall and fluoride applications; and the debonding for non-cooperative patients with consistently poor oral hygiene and non-compliance of appointments to be kept before substantial destruction takes place.

We were actually having reports of dentists that were taking off the orthodontic appliances, extracting all their teeth and making dentures on kids that were in their teens just because of non-compliance.

So, in addition to those, we made recommendations for the medical necessity for

increased cleaning and fluoride intervals. So, regarding the cleanings for the children, all the MCOs have agreed to cover this under EPSDT for medical necessity.

So, instead of six-month cleanings being covered, we can bump that up to three-month cleanings that we can apply under the EPSDT for medical necessity.

So, we think having that ability to get the patients preventive cleanings more frequently, we're hoping that drives down the amount of decay and the white spots and decalcification that we see in a lot of these patients.

In addition to that, we've gotten approval from all five MCOs to do additional fluoride treatments as well. So, instead of fluoride treatments being every six months, we can go through the EPSDT Program and do those fluoride treatments every three months on children.

They have to be preauthorized as everything through that program does but we can preauthorize those and, then, hopefully, with the increased cleaning rates and increased fluoride rates considerably decrease the amount of decay that we're seeing in this population.

The orthodontists are also being urged that if they do see non-compliance, broken appointments, very, very poor oral hygiene, to just remove the appliances. We've always said it's better to have crooked teeth than no teeth, so, just take the appliances off if that's needed.

That's all been approved through the MCOs. The KDA is disseminating this out to all the providers and we're hoping for increased positive outcomes with that.

So, it was a good collaboration between the Dental TAC and the MCOs. Commissioner Steckel was on board with it and everything. So, it worked out well. That's all I have to report.

DR. PARTIN: Thank you. Consumer Rights and Clients Needs.

MS. BEAUREGARD: Good morning. My name is Emily Beauregard. I am the Chair of the Consumer TAC and the Director of Kentucky Voices for Health.

We had a number of things that we discussed at our last meeting. We met on August 20th and we did have a quorum present which we were happy about.

I think at our last MAC

meeting, I reported that we hadn't had a quorum for a few months because we had two members who had really had a lot of trouble attending in person, one because she has children with disabilities and the other is Arthur Campbell who is a member of our TAC and has disabilities that require he have personal assistants who can help to interpret for him and also transport him to meetings.

And, so, Arthur was able to attend our last meeting and did so because he wanted to be present for a conversation about having the accommodations made to attend these meetings in the future to having meaningful participation.

And, so, he was able to attend and wanted to discuss a recommendation related to ADA compliance, so, the Americans with Disabilities Act.

While we recognize that the Cabinet for Health & Family Services' building is physically accessible, the cost of hiring a driver, an interpreter or a personal assistant is cost prohibitive for anyone but especially for someone who is disabled and doesn't have the additional resources to cover those costs.

So, in conversations with DMS, and we've been discussing this since the beginning of

the year, we have come to the agreement that the building is accessible and we understand that, but the other items that I mentioned - the transportation, the interpreter, the personal assistance - those are things that we have not seen eye to eye on.

And, so, in a response to our first recommendation around this personal assistance and transportation, just the accommodations, DMS had stated that they would comply with state laws which we appreciate, but we are talking about a federal law, the Americans with Disabilities Act.

And if the state law is not fully making accommodations, we want to look to the ADA and make sure that we are in compliance here in Kentucky with that law so that people can have meaningful participation, especially since Arthur has a Medicaid waiver, a 1915(c) waiver, and he and others who are stakeholders of the Medicaid Program want to have a meaningful role and advisory capacity and this would allow him and others to do so.

And he wanted to make sure that the MAC and DMS were aware that this is not just about his participation but anyone's participation that has a disability.

And, so, we had that conversation at our last meeting and will be making a recommendation that I will report at the end of this, but I also wanted to mention that Arthur estimated the cost for transportation and personal assistance at about $126 per meeting.

And for six bimonthly TAC meetings a year, to have the transportation to Frankfort, to have the personal assistance during the meeting, he said that the cost would approximately be $750 a year, so, really a very feasible amount of money and I think a worthwhile investment to make and ensuring that our TACs and our MAC are truly representative of the stakeholders that are part of the Medicaid Program and are served by the Medicaid Program. So, that was the really important conversation that we had at our last TAC.

Something that had come up previously and we didn't discuss this at the last meeting but I was just made aware of this, I think you're all familiar with the 1915(c) waiver redesign that's been going on and there are committees that have been formed as part of that redesign effort.

So, these committees, originally we were told that they were not open

meetings and that the people who are serving in these capacities, their names were not made public. And there was a lot of discussion back and forth over why these aren't open meetings and that these names weren't being shared and there was a legal decision that was recently made that they are open meetings.

So, I thought that that was worth sharing and we are very glad that that information is now known and that people who are serving in those capacities, their names can be made public and people can attend those meetings.

So, just some additional information to share about people's opportunities to have meaningful input into these various advisory committees.

Something else that we discussed at our last meeting which is relevant to today's discussion is about the KI-HIPP Program. And I think there was a lot of good information shared before and I appreciated the experience that you shared about your family having the coverage through KI-HIPP.

We think that KHIPP or KI-HIPP - it's really the same thing - it's premium assistance for your employer-sponsored insurance - we

think it's a good program for certain people, certain households.

And the households that have primarily benefitted from this program to date have been ones where there's been a family member who has been Medicaid eligible but most likely the rest of the family, the rest of the household has not been Medicaid eligible. They've got a higher income and they are typically going to be enrolling in employer insurance.

So, the benefit of having your entire family premium paid is pretty obvious. And for those individuals who are more middle income, to have the premium paid is a benefit and, then, you expect that you have to pay out-of-pocket costs like your copays or deductible, your co-insurance.

But when we talk about Medicaid individuals with very low incomes and Medicaid households where every member of the family is living on let's say a family of four $25,000 a year, enrolling in employer insurance and having to pay out-of-pocket costs if you go to a provider that does not take Medicaid, that's where you get into some risk that the family, then, is taking and having to pay out-of-pocket costs that can add up to hundreds

or thousands of dollars.

So, while we're not necessarily saying that this is a bad program and we're not, we think that different types of households, different types of Medicaid beneficiaries will have different experiences and face different risks and benefits in using the program.

So, we've actually worked with DMS to make some language changes that I think have helped to make it more clear what the responsibility is and what those risks are.

The other thing that we hear a lot is that it changes your network. It expands your network. Well, you have access, you continue to have access to a Medicaid network. It changes from being your MCO network to being the fee-for-service network.

So, once you enroll in KI-HIPP, you now are using the fee-for-service network. Not all fee-for-service providers participate with every MCO and not all fee-for-service providers are going to necessarily be available, or what I should say, it is not universal. All the providers that are serving MCO enrolles aren't necessarily going to be in the fee-for-service program. So, you might see a change

in your provider network.

If you go to a provider that's in network with the employer insurance but they don't take Medicaid, you're on the hook for all those additional out-of-pocket costs. So, we want people to know that, and, so, we created an Explainer to make that a little bit more clear to people.

But the other thing that is of most concern to us is that KI-HIPP - does everyone understand what a qualifying event is? It's you have an open enrollment period with your employer insurance once a year and you can make decisions to enroll, to disenroll, to change your plan.

After that open enrollment period is closed, you have to have a qualifying event in order to enroll or to make a change and that could be getting married, a different person in the household, moving, but KI-HIPP creates this qualifying event so that you can at anytime during the year enroll in employer insurance.

The reverse doesn't happen. If something happens, if you have a change of circumstance in your life and you are no longer eligible for Medicaid or you can't meet the requirements of the KI-HIPP Program, you don't get

the option to disenroll halfway through the year.

So, if you are no longer covered by Medicaid, let's say you get a small increase in your wages at work or you get additional hours, you're no longer financially eligible for Medicaid, you could be locked into that premium assistance plan with your employer or with the employer plan and be paying the entire premium yourself. Medicaid would no longer pay for it because you're no longer Medicaid eligible.

So, we have a concern that people who just make a little bit more in income throughout the year could end up having this really financial burden that they may not be able to afford.

So, those are the things that we have expressed concerns about and are working to see if we can address to make this program work for more Medicaid beneficiaries.

And we have also created kind of a decision tree for people to look at whether the program would be a good fit for them or not. So, are you able to do paperwork for two insurance plans, for Medicaid and for your own employer insurance? That's one thing. And are you able to pay a premium up front out of your pocket and wait to be reimbursed

which may take a couple of weeks or more? So, those are two questions.

And, then, you have to also look at whether or not you can pay out-of-pocket costs if you go to an employer network provider that doesn't take Medicaid.

So, those are the questions that we pose so people can decide if this is a benefit for them or not.

And, then, of course, like I said, families who have one member who have Medicaid, if they're able as a family to get their premium paid, that's a little bit more of a clear-cut benefit.

So, I just wanted to share a little more information with you about how we have understood the program and what our concerns are for Medicaid beneficiaries.

In addition to KI-HIPP, we also talked about mandatory copays which has been an ongoing conversation.

And we have also been able to work with DMS in a number of ways to make some small improvements in the KYHEALTH.Net provider screens so that the information is displayed a little bit more

clearly in terms of income rules, so, whether or not someone can or cannot be turned away if they're unable to pay a copay and that's been helpful.

We've also worked with DMS to get more information out to pharmacists about what the rules are because their systems don't look the same as what other Medicaid providers have, but we have still heard reports from people who are being turned away inappropriately.

People who are at or below 100% of the federal poverty line should not be turned away for any reason and some still are being turned away.

So, there's still more work to do to make sure that people are getting the services that they need and know their rights.

I think one thing that we have learned, we have been visiting different areas of Kentucky and doing some education. We've gone to Paducah, to Morehead, Stanford, Lexington, Owensboro and Bowling Green and a lot of people don't know their rights. They don't know what the rules are.

And, so, when they're turned away, they assume there's nothing that they can do in order to get the service or the prescription that they need, but we've heard some

really concerning situations, one being someone who was experiencing homelessness, went to the pharmacy to get medication for depression and they were unable to pay that $1 copay and they were turned away, and this is somebody with zero income.

We also heard recently from a woman who needed a cancerous lesion removed and she couldn't pay the copay and she was not seen for that appointment.

So, these are things that we want to make sure we are addressing. DMS has offered to make calls to the providers and the pharmacies and do some education whenever we get these reports. So, we're asking for people to report that information and share it with DMS.

The last thing that we discussed was the Medicaid Free Care Rule, or the reversal of this rule actually which allows schools to then provide more Medicaid services to their entire student population that has Medicaid, not only those with an IEP, and we think that this is a fantastic policy.

We're very happy to see the State moving forward with this, particularly for areas of the state that don't have as much access to

things like behavioral health and dental services but really for all the various needs that children have and the gaps in care that we see.

We do think that for this to be successful, we need a lot of stakeholders, all Medicaid stakeholders to be at the table to really ensure that the planning and the implementation is going to be effective, that we have continuity of care, that there be good coordination and communication between schools and community providers, and that there are measures in place to really encourage that collaboration, to support data sharing and to avoid duplicate billings.

So, we hope that the MAC can be involved and the various TACs in helping to design this program and to make the implementation a success.

And, then, finally, we have asked to have input into public communications and education materials related to Free Care and to these other benefit changes and programs, and this would really allow us as the Consumer TAC to make sure that materials are presented in plain language, that the language is clear and easy to understand, and we have also requested that materials that are mailed to

Medicaid beneficiaries in another language because that's the primary language that they speak, that there also be an English version of that information so that Application Assisters and others who are assisting that individual can understand and provide more effective support to them.

So, the recommendations that we made for today's meeting are as follows. The first is that DMS provide a written policy on paying or providing appropriate accommodations for people with disabilities to allow them to fully participate in meetings as a person serving in an advisory capacity.

The second is that DMS share consumer communications about new or changing programs and policies with the Consumer TAC for the TAC's input.

The third is that DMS get CMS' opinion, the Center for Medicare and Medicaid Services, get their opinion in writing regarding the following things - this will make it more clear - the KI-HIPP cost-sharing for in-network ESI providers who do not take Medicaid, for up-front premium payment requirement, and whether or not being disenrolled from KI-HIPP or losing Medicaid eligibility must be considered a qualifying event.

And, then, the fourth is that DMS provide written notice in the recipient's requested language as well as English so that anyone assisting the individual can read the notices in English.

So, that's it for our report. Our next meeting is October 15th at 1:30 and we meet at the Cabinet for Health and Family Services.

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

MR. TRUMBO: What is the revalidation on the Medicaid certification? What's the frequency of that?

MS. BEAUREGARD: I'm not sure if I understand your question.

MR. TRUMBO: You said that they could lose their Medicaid eligibility and then don't have the ability to get----

MS. BEAUREGARD: Right. You can lose Medicaid eligibility at anytime during the year if you have a change in income, for instance, or household size. The very things that make you eligible for Medicaid, if they change, you could become ineligible and that happens on a rolling basis.

MR. TRUMBO: And, so, when that happens, they don't have the opportunity, then, to get on private insurance----

MS. BEAUREGARD: That's our understanding.

MR. TRUMBO: ---because it's not a qualifying event.

MS. BEAUREGARD: It's not a qualifying event is our understanding, that you can't disenroll from the KI-HIPP Program which would mean disenroll from your employer insurance.

And, so, we understand that this may not be in the purview of DMS, that they may not have control over whether or not this is a qualifying event. It could be the Department of Insurance. It could be ERISA, the federal law that governs employer insurance, but it's still a concern that we want to make sure people understand.

If you're going to enroll in this program, if you think that your income is going to increase at anytime during the year, be prepared that you will be paying the full premium.

COMMISSIONER STECKEL: And we agree with that. We're concerned about this and am trying to reach out both to CMS and to others to see

if we can't work together on this. We agree that it is a concern.

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

MS. KALRA: Hi. I'm Mahak Kalra with Kentucky Youth Advocates and Co-Chair of the Children's Health TAC.

Our TAC met on September 11th. We did have a quorum. Our September and November meetings are focused on services for children with autism. We don't have any formal recommendations right now but we hope at the next MAC meeting that we bring some formal recommendations to you after hearing our speakers speak.

And, then, also, it seems like our January meeting should focus on the 2020 census since children are under-counted. And, so, I think that should be a goal and will be a goal of the Children's Health TAC. Any questions?

MR. WRIGHT: Have you all had any discussion related to the rate changes in behavioral health services for autism?

MS. KALRA: We haven't but that's a great question and we could add that to our list at the next meeting.

MR. WRIGHT: I know it's mostly under the private insurance, particularly with Anthem. I know we've received a lot of correspondence ourselves in the community that I'm involved with that receives ABA services and there's some growing concern in the Commonwealth of Kentucky about rate changing and some rate cuts that could impact those services drastically.

MS. KALRA: Thank you for letting us know, and I will connect with you afterwards. So, thank you.

DR. PARTIN: Thank you. And last but not least, Behavioral Health.

DR. SCHUSTER: Good morning. Let me just respond to Dr. Wright's question about the autism and Anthem. There's going to be a hearing next week at the Interim Joint Committee on Banking and Insurance. I think it's next Wednesday. You might look at the LRC website but it's on the agenda for sure. So, you might want to let you network know.

Good morning. I'm Sheila Schuster, Chair of the Behavioral Health TAC. We met on September 3rd with four of our six TAC members present constituting a quorum. We had

representatives from four of the five MCOs and a number of members of the behavioral health community. There were no DMS or DBHDID staff members in attendance.

We focused much of our discussion on a series of regulations that were promulgated on June 28th and became effective July 1. So, they're known as E regs or emergency regs and they had to do with the operations of BHSO's which are Behavioral Health Service Organizations, and these are organizations outside of the community mental health centers that provide a lot of services to people with behavioral health issues, both on the mental health side and on the addiction side.

The regulations called for significant changes, putting all of the BHSO's I would venture to say out of compliance immediately when they were promulgated on July 28th. There had been some meetings earlier in the month, but in terms of the extent of the changes required by the regs, I would say that most of the BHSO's were out of compliance.

We are particularly concerned about a change in the operation of the BHSO's who have been providing services to people whose primary

diagnosis is a serious mental illness and who may have a secondary diagnosis of an addiction or substance use disorder.

A low estimate would be that 50% of our population of people with SMI's - we call it serious mental illness - also have a co-occurring substance use or addiction disorder. It's probably upwards of 60%, maybe as high as 70%. And with this change, those BHSO's who have the primary providers on the mental health side will no longer be able to see those patients because they will not be qualified to address the substance use disorder.

Those patients will have to go to BHSO's whose primary function is an addictive disorder. Unfortunately, those BHSO's are not going to have the wealth of training and experience and clinical acumen that the BHSO's have.

So, we are extremely concerned about the discontinuity of care and do not feel that this is appropriate client-centered care.

There also is a lot of confusion about billing and units of service for people that we call peer support specialists. I think I've mentioned them before. These are folks either on the mental illness side or the substance

use side who have had treatment for either a mental illness or a substance use disorder, are actively in recovery and have had training from the State or State agencies and certification to be a peer support specialist.

They are absolutely critical to the recovery process for our folks. They're the people that you turn to almost like you do in a 12-step program that says I've been there, I've been at the depths where you've been. This is what it means when somebody says that to you. This is what your psychiatrist or psychologist is saying to you. This is what you need to do. You can call me anytime - that kind of thing.

And there are a growing number of these. In fact, the Department for Behavioral Health has this as a priority in terms of training these folks and making sure they get the certification.

Unfortunately, as some of the BHSO's read the regs, the limitation either on the units of service or the cut in rates will not allow people who actually have worked their way off of Medicaid, which is something that this Administration really obviously supports and promotes, to full-time

employment, as we read the regs, they would not be able to bill enough services to remain full-time employees which it would put them back in terms of their earnings anyway back onto the Medicaid rolls and so forth which seems really a backward step. So, we're looking for some clarification on that.

We also asked the MCOs to come to the meeting with a report on changes they had made in their psychotropic medications since the first of the year.

One MCO provided a list of changes which numbered fifty-one. Three other MCOs gave a verbal report of significantly fewer, two, three or fifteen changes, and I"m still waiting to hear from the fifth MCO.

We are concerned about the cumbersome appeal process and the short notice that providers get, particularly with the start of school because one of these changes affected one of the more commonly prescribed treatments for ADHD or Attention Deficit Hyperactivity Disorder.

So, you have kids that may have been weaned out or weaned off of the medication during the summer. The psychiatrist or psychiatric nurse practitioner is seeing them in a preschool

evaluation and writes the prescription and it gets denied by the MCO and this is something that they've been on successfully for a number of years.

We're very concerned. There's been a theme, I think, for those of you who have been here as long as I have, there's been a theme from our TAC that one of the most critical issues for our folks is access to the appropriate medication and the appropriate dosage at the time that they need it.

So, anything that creates a barrier for the prescriber or for the person getting the medication which is why we worry about the copays really sends our folks down a downhill spiral. And very often, then, they become non-compliant with their medications and, then, we end up in that cycle of homelessness and repeat hospitalizations.

We appreciated getting the information from Sharley about teleconferencing. I thought it was clear and helpful. We've not had a problem with having quorums at our TAC meetings and, so, probably will not use that.

We continue to look at the issue of EMS refusing to transport individuals with behavioral health issues and we will be getting back to DMS with specific information about specific cases

of an individual - name, place, serial number, name of the EMS transport and so forth.

We made these recommendations and they were approved unanimously by the TAC members. We had previously recommended that DMS communicate with the relevant TAC or TACs before making a significant change in policy, reimbursement or regulation so that we could have input on it beforehand. We had thought that the TACs were advisory to DMS, but DMS has informed us that the TACs are advisory to the MAC which then is advisory to DMS.

So, we will be making our recommendations and requests directly to the MAC and hope that this affords an opportunity for better communication with DMS so that all of us can be responding proactively rather than reactively.

MR. CARLE: Sheila, can you back up for one second on the EMS refusing to transport individuals? Are there certain hot spots? Do you have usual suspects or is it rampant throughout the state?

DR. SCHUSTER: It's rampant throughout the state as much as we can tell, Chris. The original complaints came from the Ashland/

Morehead area, but as we talked to--we have representatives from all over the state that come to our TAC meetings. And, so, we heard at that particular meeting from Prestonsburg, from Northern Kentucky and from Somerset that it was happening in those communities as well.

I also understand and I talked with the Chair I think at that last meeting that it's happening out of primary car offices, too, that you may have somebody who seems to be in acute distress and you want to get them to a facility with a psychiatric capability and so forth and that EMS is refusing to transport.

The problem may be in the reg. We've begun to look at that because it looks to us in the reg that if the person is able to walk I think the reg says, then, EMS doesn't have to transport. I don't see how that's the case, but it looks like you have to need a stretcher to be transported. So, if that's the case, then, maybe it's a reg problem as much as anything else.

What we were hearing from EMS responders at that point was we don't have to take crazy people. We don't have to take behavioral health patients. And, obviously, at the last

meeting, we turned to the Commissioner. Obviously, nobody is saying that that's accurate but that's kind of what's out there and it's across EMS providers apparently.

MR. CARLE: I didn't mean to backtrack.

DR. SCHUSTER: It's been a huge issue. Thank you.

We recommend that the MAC request that the regulation governing the operations of the BHSO's - and I've got them listed here - promulgated as emergency regulations be withdrawn.

Since these regulations went into effect immediately, it's impossible for the BHSO's to be in compliance and I've talked about the negative impact on our folks.

We recommend that the MAC request the DMS Commissioner or other DMS personnel to respond to these questions concerning the BHSO regs. What prompted these regulations and what is their intent? Why were they promulgated as emergency regulations when the changes are so significant and nearly impossible to implement in a short period of time? Have you considered the impact of these regs on those Medicaid recipients currently being treated

in a BHSO I who also have a secondary substance use disorder?

Were you aware that the change in units of service for peer support specialists would make it impossible for them to maintain the full-time employment that they currently have? And can you clarify the payment rate and billing code for group work provided by peer support specialists?

We also had a question about the implementation of the single credentialing agency and recommend that the MAC request a time line from DMS for the implementation of that. That was House Bill 69 in the 2018 Session and Senate Bill 110 in the 2019 Session.

We recommend that the MCOs be required to give a 60-day notice to prescribers of any changes in their formulary so that prescribers will have sufficient time to fully understand the changes, the appeal process for individual cases and can modify their prescribing patterns accordingly.

We recommend that changes made by the MCOs to their formularies be reviewed by the DMS P&T or Pharmacy & Therapeutics Committee, with notice of the review posted in the agenda of that particular P&T Committee meeting.

I might point out, we used to have representatives at all of the P&T Committee meetings when there was a single formulary. It is quite frankly impossible to do that with five MCOs, five formularies and very little notice, and many of those P&T Committee meetings for the MCOs are held at some hotel outside of O'Hare Airport in Chicago or that kind of thing.

So, the inability of consumers and providers around specific populations on changes in formulary is essentially nonexistent and we keep trying to get DMS to intervene in that process and give us at least some notification period and some opportunity to respond.

And, finally, and Steve announced this at the last meeting, we didn't want to meet on Election Day. So, we're meeting on November 4th at 1:00 p.m., Room 125 of the Annex, and we will be setting our 2020 meeting dates at that point.

Any questions?

DR. PARTIN: Thank you. So, having heard the recommendations from the TACs, do we have a motion to accept the recommendations?

MR. WRIGHT: So moved.

DR. PARTIN: Second?

MS. ROARK: Second.

DR. PARTIN: Any discussion? All in favor, say aye. Opposed? So moved. Thank you.

We're going to move on to New Business, and the first item on New Business is the new DMS urine drug testing policy, and I would just like to speak to that for a minute and then hear what you all have to say.

As far as primary care goes, the standards for the urine drug testing seem fine to me. I think sixteen a year is sufficient.

The onsite testing is basically pretty worthless because people know how to get around that and also they're not very accurate. So, you can't really depend on a result that you get from the onsite testing. That's with the little bottle and you just look at the--there's a little bottle and it has a little strip on it and it's supposed to tell you whether or not the drug is in the urine; and if you Google that, there's like two thousand ways to get around that test.

So, the point-of-care testing is really pretty useless, and, so, that number twenty-nine which is allowed and people do use that

but I think it's pretty worthless. The definitive testing is number sixteen, and, like I said, I think that works for primary care. I don't think it works for medication-assisted treatment for MAT.

When you're prescribing for those people with substance use disorder, I think you have to be very careful and conscientious about the medication that you're prescribing, and in most cases it's Suboxone, and could be very dangerous if the patient has, say, Benzodiazepines, in their system and then you prescribe them the Suboxone. Depending on how much they have in their system, it could be lethal.

And, so, you need to know not only if they have the drug in their system but you need to know how much drug they have in their system, and the only way to do that is with the definitive quantitative testing.

And, so, I don't think and other people that I've talked to who prescribe MAT don't think that the sixteen number is adequate for that population.

And, so, I would respectfully ask that this policy be amended to allow the discretion of the prescriber actually for the urine

drug testing for the definitive testing with MAT.

COMMISSIONER STECKEL: With all due respect, let me, if I could, Madam Chairman, explain the process that we went through with this and then I will turn it over to Dr. Theriot.

This started as a Program Integrity initiative. It is one of the areas where we find most prone to flat-out abuse and fraud.

So, we had to look at it, and, unfortunately, as you all know, a lot of the rules and regulations we have are because somebody in your profession did something and now everybody, whether you're good, bad or indifferent, has to follow the same rules. We have to follow traffic rules. We have to do things that we don't like to do.

So, this is an area that I have to look at as a very significant potential fraud area.

So, given that, how do we provide the services that are medically necessary and how do we make sure people are getting the services, particularly, it's important in every area, but particularly in this area.

So, one of the things that we did is we brought in addiction specialists, and I'll

have Dr. Theriot talk about who they are and all of that. So, we started with the addiction specialists. We put no restrictions on them. We didn't say we look at it with a budget perspective. We didn't say look at it with a fraud perspective. We said what's right for the patients that we're trying to serve.

Then we brought in the other physicians and we brought in the labs. So, this has been a carefully thought-out, very carefully vetted process. So, I will turn it over to Dr. Theriot and she can talk in much more detail.

DR. THERIOT: And we did go through the process with the addiction specialists first because we didn't know--we tried to look it up to see some of the advices from the national organizations and they were very vague.

And, so, then, we got our addiction specialists in to meetings in Kentucky and basically learned what they did and what they suggested that we do. We also looked at what other states are doing.

Pretty much overall, our specialists decided what the other states were doing were too limited. And, so, what our recommendations, what we came up with are much more liberal than our

surrounding states, especially where it comes to the definitive drug testing.

But also one thing I didn't know, one of the codes for the presumptive testing is an analyzer code. So, yes, you have codes that are the ones that are pretty much useless when you just collect it in a little cup, but one of the codes, many of the addiction specialists have an analyzer in their office and it's more--it's just a better test. It's still a presumptive point-of-care test but it's just better.

And, so, that's one of the reasons there's so many in the presumptive category and it's actually thirty-five total without breaking it out for those tests.

COMMISSIONER STECKEL: And does this preclude someone from if they need the seventeen tests getting a prior authorization?

DR. THERIOT: No. And everyone thought that this would cover 95% of the patients without having to do anything else. And, then, if you need more tests, you do a prior authorization to get more tests.

DR. PARTIN: But how would you do the prior authorization if you have the patient

onsite that day? You won't be able to get the prior authorization in time to do the test.

DR. THERIOT: There should be some counting of it but just documenting. We've asked the doctors to document the medical necessity of the tests which is not always done and, then, you have that information to go ahead and proceed with getting your prior authorization.

DR. PARTIN: Right, but what I'm saying is you have to get the authorization before you do the test and you have the patient there and you can't get the authorization that fast.

COMMISSIONER STECKEL: But you should know that that patient is at sixteen, and if they come in to your office for an appointment, you're going to want to do that test.

So, in essence, what we've done is we've lifted the PA process. So, for a no PA process, you can have a thirty-five and a sixteen. So, it's incumbent, then, once you hit that sixteen, then, you have to go through the PA process, and, again, not based on bureaucrats but based on addictionology specialists.

DR. PARTIN: So, looking at the codes on here, the first one with the twenty-nine,

I'm assuming that's the point-of-care testing.

DR. THERIOT: Actually it's thirty-five. It's thirty-five. You might have an older version of that.

DR. PARTIN: This policy I have it says twenty-nine. It says presumptive UDS codes, maximum twenty-nine and I was assuming that's point-of-care testing.

DR. THERIOT: That's point-of-care but it's actually thirty-five and, then, there's sixteen definitive.

DR. PARTIN: And, then, there's another one that's another code that says presumptive UDS that says number six.

DR. THERIOT: Those have been combined into the thirty-five.

DR. PARTIN: So, the 80305, 80306, 80307 are all point-of-care testing, not analyzing?

DR. THERIOT: Well, they're all lumped into the thirty-five. They are point-of-care testing but that 80307 is the analyzer we were talking about.

DR. PARTIN: Okay. Okay. So, actually, then, because the analyzer is helpful.

DR. THERIOT: Is better, yes.

DR. PARTIN: And it does give you quantity. So, that would be helpful. So, really, it's twenty-two that you could have more definitive, right, because you could have the definitive sixteen and, then, you could have six with the analyzer.

DR. THERIOT: That's correct, depending on how you're counting that 80307.

DR. PARTIN: Okay. And, then, it does say in the policy that the - I forget where it is now - I should have underlined it - but, anyway, that the provider could request a waiver. Is that the prior authorization that you're talking about?

DR. THERIOT: Yes, ma'am. And we built it in assuming--we came up with the numbers or the addiction specialists did, assuming that you're going to relapse at least once or twice and, so, that's why the numbers are so big.

So, if somebody has one relapse, you don't have to run and get a prior authorization. So, this should account for the majority of the patients without the providers having to----

DR. PARTIN: Could you say that again? I'm sorry.

DR. THERIOT: The numbers are so big to try to account for patients having one or two relapses during that first year of treatment. So, if that happens, we're trying to account for it because it's a common occurrence and the provider should be covered with this limit on the testing. It's just beyond that that they would have to get a prior authorization.

DR. PARTIN: Okay. I don't prescribe MAT but I think that there are some concerns in the community from some of the people who do. And, so, maybe I will get more feedback from them and I can bring that at the next meeting, if that's okay.

DR. THERIOT: That would be great.

COMMISSIONER STECKEL: And certainly we're open to any comments or suggestions but we have done that already by bringing in the addictionology specialists at the beginning and bringing in the labs at the beginning. We will be very reluctant to change this policy.

So, certainly, if there's

something that everybody that has worked on this has missed from the universities to Dr. Theriot to us, everything, then, certainly we will look at it, but I don't want to leave the impression that it's going to be easy for us to open this up again.

We believe that we have been generous, especially compared to other states, and we've done it the right way by starting with the addiction specialists and not putting parameters around them.

DR. PARTIN: And I understand that, and actually showing that the six can be with the analyzer, the onsite analyzer, I think that makes a difference. And, so, I will take this back to the group who approached me about it and I think that might make a difference with them.

COMMISSIONER STECKEL: Well, and if there's a better way for us to explain it, certainly Dr. Theriot can get on the phone or if people want to come visit with us. If there's a way for us to walk people through the policy, we will do that absolutely, but I don't want to leave the impression that this is a policy that will be easily revisited.

DR. PARTIN: Okay. I

understand.

COMMISSIONER STECKEL: Okay. Thank you.

DR. PARTIN: Next on the agenda is DMS role in advanced care planning. Chris.

MR. CARLE: I just thought it would be time well spent to discuss what DMS is doing with regards to advanced care planning related to their patient base that is rather large.

COMMISSIONER STECKEL: I agree, and having just recently had to make multiple copies of advanced care planning documents, I can totally relate to this.

I don't believe we're doing anything and certainly we can look at this. I don't even know where to begin on how we would start this with our beneficiaries, to be honest. I am a supporter of advanced planning documents.

Maybe one of the things we could do is talk to the Consumer TAC and get their thoughts on what could we do in this area, how could we encourage Medicaid beneficiaries to have an advanced planning document and do it in such a way-- here's what I don't want.

And this is going to be crude

and rude and I apologize ahead of time. I don't want a headline that says the Medicaid Director, in order to save money, is trying to get people to choose to die.

MR. CARLE: Correct.

COMMISSIONER STECKEL: But I think it's important for, having been surprised when my mother gave me her advanced planning document, I would have thought she wanted one thing and it was completely different. I think that discussion, that that's an important discussion for families and for beneficiaries to have.

How we do it in such a way that it's sensitive. So, if it's okay with the MAC, I'll be glad to engage the Consumer TAC and see how we do that.

MR. CARLE: Well, I think maybe prior to that, we are having these conversations with those individuals and their families within the hospital in the discharge planning process if they have to go to hospice or if they're admitted to palliative care.

So, we can provide a reference for you. I think, though, it needs to be a team approach, a joint approach.

So, I guess we could start that. I can put you together with a couple of resources that I think are doing a fabulous job with this. That's where I actually even came up with the idea of asking you this question as to how DMS is actually doing it, and maybe that would be a good start for you.

And, then, also, then, once you get that as a baseline, then, I think you can approach the Consumer group to find out what they're doing, but all the hospitals are actually having to do this, and I just think it's a very worthwhile endeavor.

COMMISSIONER STECKEL: I totally agree with you. So, we'll get together and I'll be glad to do that.

MR. CARLE: Great. Sounds good. I appreciate your candor related to it.

COMMISSIONER STECKEL: Thank you.

DR. PARTIN: Okay. Next is the item about confusion regarding copays, and this was brought to my attention by Peggy based on some personal experiences that she had. So, go ahead, Peggy.

MS. ROARK: I'm Peggy Roark, a medical recipient. I just have general questions on how does a patient know they've met their deductible and do they have a chart that the patient or the doctor because even the doctors that I've met are confused on one time it's a $3 copay, next time it's nothing. And, then, in the mail, you get $3 back reimbursed. So, it's confusion for the doctor and the patient.

COMMISSIONER STECKEL: Yes, ma'am. And this is an area that we have worked very hard on, and the issue comes in the end of the quarter. So, if you have gone - let's say January, February and March - so, you go to the doctor on March 20th, you may have a zero copay because you've met your 5% limit of your income.

And, then, you go to another doctor on April 10th, you have to pay a $3 copay because it started a new quarter.

And, so, that is part of the issue is educating folks on the issue that it's 5% of your income per quarter. So, every quarter is an independent entity.

The other thing that we've done is we've worked with the pharmacists and with our IT

systems to make sure that there's clear information both about individuals that are at or below 100% of the poverty level so that the providers know that and where that recipient is or that beneficiary is on their copay, whether they've met that 5% or not.

So, it is an area that we are working on and I think we've done a lot of work on trying to make that more clear, particularly in the pharmacy area, and it's just going to be continued education.

MS. ROARK: Well for example, is that based on them working or they're volunteering? There's certain things they've got to meet to----

COMMISSIONER STECKEL: This is not related to--now, Kentucky HEALTH is not being implemented. So, the copay would be 5% of your income. So, if somebody has spent in premiums - and I know, Emily, you all will jump in if I get off kilter on this - if you've spent 5% of your income, then, you go back to zero and you don't pay a copay.

So, if that happens on January 15th or if it happens on March 31st, it doesn't matter, but it starts new on each quarter. So, April 1st it would start new and you would have to spend

that 5% of your income. So, whatever your income is, it would be the 5%.

MS. ROARK: And, then, if a patient has no income but they need copays for the doctors or the medications----

COMMISSIONER STECKEL: If they don't have any income, then, they wouldn't be--there are certain people that are exempted from copays, but if they have zero income, then, they wouldn't pay - I'm embarrassed that I have to call an expert. Emily?

MS. BEAUREGARD: Our understanding of the copay policy right now is that if you have zero income, you still pay the nominal copay. It can be $1. It's a small amount but it will still be charged.

Now, the rules that I mentioned before, the income rules are that if you are at or below 100% of the federal poverty line, pharmacies, providers are not supposed to turn you away if you can't pay that copay but they can still charge you that copay. They can ask for it.

So, when I say they should not, I mean, you know, they're not supposed to but they can. In practice, that happens.

So, we've seen that people are charged a copay. They say I can't pay it and, then, they get turned away because maybe it's the front office receptionist doesn't know the rule. Maybe they're not reading those screens.

There could be a lot of reasons that it's happening and it happens inconsistently. So, you could go to one provider and they may still see you and at another provider, they will turn you away because some of this is up to the provider's discretion, but there is a charge that you will still get.

The rule is that you shouldn't be turned away or you can't be turned away but we know that it happens.

COMMISSIONER STECKEL: And that's where we've worked on our IT systems so that all of the providers can both see when somebody is at or below 100% of the Federal Poverty Level. So, that triggers what Emily was just talking about, not being able to turn somebody away.

So, now providers can actually see that. We had it turned off for good reasons at the time we thought but we've turned that back on.

And, then, the other thing is

the actual 5%. The providers can see that now.

MS. BEAUREGARD: I'll just make one more comment. I do think that this speaks to the confusion that both providers and, of course, Medicaid beneficiaries have regarding the copay policy because, as far as we know, in the regulation, some of those rules aren't spelled out very clearly in detail in terms of who can be charged a copay and, then, what the rule is, depending on their income, if they can be turned away or not turned away.

A lot of that is not in the regulation. So, unless there is a written policy that the provider has that they follow and can provide that policy to the Medicaid beneficiary, this information is just not known, and most Medicaid beneficiaries, I would almost say all, don't know that there's a 5% cap on out-of-pocket costs or that it's calculated on a quarterly basis.

So, this is the type of information that we kind of making assumptions about, but when you get right down to people who are using health care services every day and even the people who are providing them, these are individuals who just don't know this level of detail about the policy and, so, aren't making decisions based on that

information.

So, I think having a written policy from DMS that providers can follow would be helpful but, then, providers also my understanding is should have a policy in writing and they should follow it consistently.

So, for instance, if you have someone who has no income or very low income and you say, well, let's say it's above 100% actually, so, you have somebody who makes $16,000 a year and you say I'm not going to see you because you didn't pay your copay, and, then, you have another person comes in who also is above 100% of the Federal Poverty Level, if you see them, then, you're being inconsistent.

You are cherry-picking or being biased in who you are agreeing to see and who you aren't. And, so, the policy should really be that you see everyone or that you turn people away based on the same criteria and that's our understanding of the rules, but I don't think providers understand those rules.

MR. WRIGHT: Can I ask a point of clarification? So, rules and policies and regulations kind of get muddled to me. So, when you

say rules and you say policies and regulations, are you saying under CMS rules, federal rules and they should supersede state rules - correct me if I'm wrong - because that's the pay source for the State of Kentucky?

MS. BEAUREGARD: My understanding has been that this is a CMS rule regarding the 5% cap and who can and cannot be turned away based on their income.

COMMISSIONER STECKEL: That is correct. It's a CMS rule. And, so, what should happen is you have the CMS rules, regulations, guidance informing what we do in our regulations, our guidance and our rules and hopefully they're consistent except where CMS allows us to make a determination, but both of these are CMS requirements, yes.

MR. WRIGHT: I agree, then, we need to have some consistency across the board.

And my next question would be what about medically deemed necessary, like waiver participants?

COMMISSIONER STECKEL: That's a Kentucky HEALTH designation. So, it will not come into play until Kentucky HEALTH is implemented after

the courts have made their decisions.

MS. BEAUREGARD: So, currently right now the copay regulation exempts pregnant women, children and people who are in hospice care and not other people who would have disabilities or other reasons for exemption under the Medicaid waiver.

DR. PARTIN: So, related to that, then, because that's new information to me about the 5%, so, this is kind of a double question. If the patient no longer is required to pay the copay--let me back up. When the patient pays the copay, then, that copay is deducted from the reimbursement that the provider gets.

So, when the patient now no longer has to pay a copay, is their reimbursement increased by that $5 from the MCOs and from Medicaid?

COMMISSIONER STECKEL: It'S not increased. It's not decreased. Does that make any sense?

DR. PARTIN: No.

COMMISSIONER STECKEL: So, if you get $10 for a procedure, then, if a copay is due, we may reduce that by $3. If a copay is not due, you still get that $10. It's not increased by $3.

DR. PARTIN: Okay. Okay, but it's decreased when they make their copay.

COMMISSIONER STECKEL: Correct.

DR. PARTIN: And, then, when they've met their 5%, then, it goes back to the----

COMMISSIONER STECKEL: And there's no change to the reimbursement.

DR. PARTIN: It goes back to whatever the rate was for reimbursement.

COMMISSIONER STECKEL: Correct. Correct.

DR. PARTIN: And we're going to be able to see that now when we go to the website?

COMMISSIONER STECKEL: You should, yes. You'll be able to see both where someone is at or below 100% of the poverty level and you should be able to see whether they've triggered that 5%, yes.

DR. PARTIN: Okay. Boy, it just gets really complex.

COMMISSIONER STECKEL: Well, but it's not any more or less complex to what you and I have to do when we go in to a health care provider and what your practice has to do with any other insurance company. We're just asking Medicaid

beneficiaries to be part of the health care system.

DR. PARTIN: Right. No, I'm not questioning that. What I'm saying the complexity is is that sometimes they have a copay and sometimes they don't have a copay.

COMMISSIONER STECKEL: I understand.

DR. PARTIN: But with the other insurance, you've always got a copay.

AUDIENCE: Until you reach your maximum out-of-pocket.

COMMISSIONER STECKEL: Correct. Correct.

DR. GUPTA: Commissioner, what is the purpose of charging those patients that fall under the poverty line a copay when they're not actually ever required to pay it? It seems like it just makes it so much more confusing for everybody.

COMMISSIONER STECKEL: Well, we believe that there is a good policy for asking Medicaid beneficiaries to be part of their health care system and being financially part of their health care system.

DR. GUPTA: I totally agree. No, I totally agree with that, but I'm saying the

ones who fall under the poverty level----

COMMISSIONER STECKEL: Because some do pay it.

MS. HUGHES: From what Stephanie has told me is that they are not required. They're not exempt is what I'm trying to say.

COMMISSIONER STECKEL: Correct, and there are people who do pay their copay that are below 100% of the poverty level and we should encourage that.

DR. GUPTA: That would be great. It just seems that if they're being turned away because of the lack of education on both parts----

COMMISSIONER STECKEL: That is training, communication and education, not a bad policy, and we agree with you on that. We are working on making sure that everybody has the information they need to make correct decisions and we're also trying to get the word out to all of the providers and our beneficiaries as much as we can.

DR. PARTIN: So, if the patient pays the copay and they don't need to pay it because they've already met their 5%, then, that money is recouped from the provider?

COMMISSIONER STECKEL: The

money would be sent back to the beneficiary. The system is going to do that.

DR. PARTIN: Then, the provider is going to get a recoupment letter?

COMMISSIONER STECKEL: The provider won't get a recoupment letter and nothing will happen to the provider payment, but the provider should know not to charge a copay because they'll look on the system and see that that beneficiary has hit the 5%.

DR. McINTYRE: I just have a point on the last point.

COMMISSIONER STECKEL: Okay.

MR. WRIGHT: Can I ask another question? When the money is sent back, who is paying the postage on that? Is that DMS paying the postage on that?

COMMISSIONER STECKEL: Yes.

MR. WRIGHT: So, if you're sending back a copay that should have never been, we're having the burden of sending back the postage cost on that, too?

COMMISSIONER STECKEL: Right. That's why we want to get it right, correct.

MR. WRIGHT: Okay. I think

that's important as well.

COMMISSIONER STECKEL: Yes, sir, we totally agree.

DR. PARTIN: Dr. McIntyre, you had a comment.

DR. McINTYRE: Not until you're finished on discussing the copays. I have a point to make on the last discussion about end-of-life care.

DR. PARTIN: Okay. I'm finished.

DR. McINTYRE: Something everybody ought to know about end-of-life care, EMS does not honor those documents. They only honor if it's on their own paperwork which is really important. If you have a cardiac arrest, EMS comes to the door. Whether you want it or not, whether the family wants it or not, you get CPR, you get everything until you get to a hospital where they will honor your do-not-resuscitate paperwork.

DR. PARTIN: Okay. Thank you.

COMMISSIONER STECKEL: That's interesting. And may I raise one other issue. Thank you, Dr. McIntyre. You've actually triggered something else.

On the EMS issue, we are

working with the ambulance providers on another provider-specific tax issue that they come to us, and I have specifically raised the issue of behavioral health transports.

And one of the reasons why we're asking for specific information is I'm in a he said/she said situation where the ambulance provider is, oh, no, we do it, we do it, we do it and tell us specifically where we're not doing it.

But there's also something that CMS sent out recently that is expanding what we might be able to do in Medicaid with EMS providers and that's actually look at having paramedics do more than just transport and maybe even have as part of their job description is transporting to a secondary location like a behavioral health provider or maybe an urgent care center instead of an emergency room.

It is something that I'm looking at now that we're talking about within DMS but that I would like to bring together a group of folks and see if this isn't an opportunity for us to address some issues in EMS.

We had a pilot in North Carolina around Raleigh and it was a phenomenal success, but just so that you all know that's

something that we will be looking at also.

MS. MORGAN: Just a question. Have you actually addressed this - you said the ambulance providers and I assume you mean the Ambulance Providers Association. Have you also worked with the Board of EMS on this?

COMMISSIONER STECKEL: I haven't with the Board. There are two associations, one that's county government-owned and one that's private-owned. I've dealt with the two of them but I haven't with the Board.

But once we can quantify some examples, then, absolutely, that's the next step.

MS. MORGAN: The Board is very active on these issues and very active with the Ambulance Providers Associations as well. So, I'm happy to make that connection if I can.

And, then, one clarification on the DNR forms. While EMS does try to require their own forms, there was MOST legislation on a MOST form is what it's called which is an across-the-board form I believe in 2016. That statute was actually codified to allow patients to fill out a form that would work for all providers. It's called the MOST form.

MR. CARLE: But I'm actually glad to hear that you're looking into the EMS, specifically with the paramedics. We have run up against the paramedic world in the State of Kentucky because they are not necessarily interested in that which surprised me. So, anything that you could do along those lines, that would be fantastic.

COMMISSIONER STECKEL: We're excited about it. And like I said, I've seen it work in Raleigh, and, so, to see how it might work here is something that - or it may not. I don't know the answer to that, but I think it will be something that will benefit us. So, we'll be looking into that.

DR. PARTIN: If it's helpful to you, the reason that I've gotten - and it doesn't happen that often - but if I have a suicidal patient in the clinic, they say that they can't be liable because the patient might jump out of the ambulance. So, that's why they won't transport them.

COMMISSIONER STECKEL: And I know this sounds like a cop-out but I promise you all it isn't. If you could tell us the date - and we can do this HIPAA compliant - but the date it occurred, the patient. Then that way we've got something specific that I can say to them, and, then, if I need

to, to go to the Board to say, look, here is a specific example. There's no way you could wiggle out of this. Either tell me what you did, how you responded and particularly if it's a Medicaid beneficiary. It just gives us the ability to actually do an investigation instead of what I'm getting now.

DR. PARTIN: Sure. It just doesn't happen that often that we have to transport somebody, so, I don't have the examples, but, anyways, that's what we've been told in the past.

COMMISSIONER STECKEL: I have no reason to doubt it doesn't happen. I just am in a situation where I have raised it and raised it in a tone that this is not acceptable, but their response back is we do it. Give us an example. Tell us where we don't, and if I can't come back with that, but I'm willing to do that. So, if they're not doing it right, I'm willing to go as strongly with them as I am with anybody else.

DR. PARTIN: We appreciate it. Thank you.

COMMISSIONER STECKEL: Sure. Any other questions?

DR. PARTIN: No, I don't think

so.

Okay. Five more minutes. And our next item on the agenda is the election. I understand that the candidates are the same candidates that are in the current positions right now.

MS. HUGHES: That's what they were before July when I asked you all at the July meeting. I don't know if any of the new members want to consider

DR. PARTIN: Okay. So, right as of now, the Chair would be me, Vice-Chair would be Chris, and Secretary would be Teresa. And if anybody else wants to throw their hat in the ring, you're welcome.

MR. WRIGHT: I move we accept those nominations by acclamation.

MR. PROCTOR: And I second.

DR. PARTIN: Any discussion? All in favor. Opposed. Okay. Thank you.

Is there any other business to come before the Council. Then, the meeting is adjourned.

MEETING ADJOURNED