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NURSING FACILITIES TAC

Tuesday, January 8, 2019

Commencing At 1:00 p.m.

Ending At 2:10 p.m.

CHFS Building

Frankfort, Kentucky

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MR. SKAGGS: I am Terry Skaggs, and before we get the meeting started, I know a sign-in sheet went around, and we were kind of getting the idea of who was here. But would everybody introduce themselves very quickly so we know who all is in the room.

MS. JOHNSON: My name Betsy Johnson. I'm just here as an observer, but I'm the president of the Kentucky Association of Healthcare Facilities, and I also serve as the executive director of the Kentucky Center for Assisted Living.

MR. JOHNSON: Wayne Johnson, also with the Association. I'm the VP of Finance.

MR. LEWANDOWSKI: Adam Lewandowski, administrator at Cold Spring, still part of the Cave Spring.

MS. McINTOSH: Sarah McIntosh with Hargis & Associates, and also chair of the billing --

MS. LEHMAN: Janine Lehman with Wells Health Systems, and I do the MDS training.

MR. TRUMBO: Jay Trumbo with Health Systems of Kentucky, and on the MAC and TAC.

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MR. GRAY: David Gray with the Cabinet for the Health and Family Services.

MS. HUNTER: Jill Hunter, Medicaid.

MS. STECKEL: Carol Steckel, Medicaid.

MS. HUGHES: I'm Sharley Hughes, and I'm going to be your all's Medicaid liaison so for the TACs.

MS. GUICE: Lee Guice, Medicaid.

MR. BECHTEL: Steve Bechtel, Medicaid.

MR. SKAGGS: All right. I know the court reporter sent out the minutes last time. Are there any modifications, corrections, anything to those minutes? If not, we'll just move on. I don't think anybody has to approve them.

Before we go into the agenda, I'd like a minute to note this, that in the future meetings, we're going to place some different focus on the discussion topics included on the agenda. In the last MAC meeting, the -- I'm going to put you on the spot. Commissioner Steckel stated that the purpose for the TAC and the MAC should be to deal

1 with systematic issues affecting providers.
2 And with that in mind, during our past TAC
3 meetings, the agenda topics have dealt more
4 with detail issues, such as information
5 systems, billing, eligibility issues, that we
6 think can be individually addressed by
7 association staff members and/or our
8 committees with the appropriate Medicaid,
9 DCBS, day old guardianship representatives
10 rather than taking up the allotted time here
11 in this TAC meeting.

12 So our intent from this point forward is
13 to highlight important issues that are
14 critical to nursing facility providers around
15 the state. The issues included on today's
16 agenda are of primary importance to ensure
17 nursing facility providers are able to
18 provide quality care in the Commonwealth.

19 So with that, we'll get started with the
20 agenda.

21 The first issue that we have on the
22 agenda is to obtain full inflation, July 1,
23 2019, and we'll go into some detail.

24 Wayne, have you passed out the
25 information? Are you going to?

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MS. STECKEL: Would you mind if I just added to your comment?

MR. SKAGGS: Absolutely.

MS. STECKEL: Because I am thrilled to hear -- because I came prepared to repeat exactly what you said, so ditto. I'm very excited about that, and we are sincere in wanting the policy discussions, and we'll be bringing things that are, you know, maybe early ideas that are neither good or bad, but that we'd like to try out with you all and hope that you'll do the same thing with us. And the more we know about the -- I mean, you've got a ringer in your organization, so but the more you know about the, not hardships, but the obstacles we have to face, the better we can design a program that does work on behalf of our beneficiaries. So we're excited about the direction that you're taking the committee.

I have one concern in that there is only representation from one long-term care organization. It needs to be more representative of others. So --

MR. SKAGGS: Actually, the Leading

1 Age is supposed to have a seat on the Board
2 or on the advisory committee, and we have
3 reached out to Tim Veno on several occasions,
4 multiple occasions in the past, asking him --
5 but we've reached out to Tim and asked that
6 they appoint someone. In fact, I think
7 Wayne, knowing the makeup of both
8 associations, has even made some
9 recommendations on some very key, financial
10 individuals within the Leading Age
11 organization. Tim's just not just appointed
12 anyone at this point in time. So maybe
13 coming from the Cabinet it might spark, you
14 know, light a fire to get that individual
15 here.

16 It's our concern, as well, because we
17 don't want a situation where we're having a
18 discussion with you and then Leading Age
19 comes in behind us and they've got a
20 completely different agenda.

21 MS. STECKEL: Right, right.

22 MR. SKAGGS: We feel like the
23 issues that we've got coming up today are
24 stellar issues in both associations. We, as
25 an association, had a meeting November, late

1 October, early November. We actually brought
2 Leading Age and the Leading Age board and our
3 board together. There were more
4 representatives from our board than there
5 were from Leading Age, but we did get them
6 together that night to start opening the
7 dialogue. Their Chair was a good friend of
8 mine. I'm the Chair of the Kentucky
9 Association of Healthcare Facilities. So we
10 worked together and put that meeting
11 together. We're reaching out more. We're
12 trying to make sure that when we come to
13 Frankfort with issues, it is being
14 communicated to Leading Age so that they're
15 not going to, you know, come in -- so but I
16 would love to have someone from their
17 organization here. I mean, for years Bob
18 Koester served for them, and Bob retired
19 several years ago, there hasn't been an
20 appointment.

21 MS. STECKEL: So in light of that,
22 and, thank you, and I'll reach out to Tim and
23 see if we can't get them to be involved
24 because it would be important to all of us
25 for all the reasons that you said.

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You'll be hearing some of the other things that we're changing. We're going to go through the calendars and make sure we're not overlapping meetings. The leadership can be at the meetings that we'd like to be at. I don't think --

MS. HUGHES: There is one. Your all's July the 10th meeting does overlap, and I can either ask you all to change or the other TAC to change. You're the first meeting that I've come to that had an overlap.

MR. JOHNSON: I believe it was the 9th and we changed it to the 10th, actually, initially.

MS. HUGHES: Actually, the 10th is just a really busy day with TACs. If we can do it another day, we could do it the 11th, that afternoon, at this same timeframe.

MS. JOHNSON: Could we do it on the 9th?

MS. HUGHES: The 10th is what it is currently scheduled for.

MS. JOHNSON: We initially took the 9th which is a Tuesday, which is --

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MS. HUGHES: It would be an overlap, then, on Tuesday, also. We can do the 16th if you want to keep it on a Tuesday, or the 2nd. Wait, that might be a bad week to meet because of the 4th of July holiday. People take vacations.

MR. SKAGGS: I can do 11th or 16th.

MR. JOHNSON: Yeah.

MR. SKAGGS: Everyone else?

MS. HUGHES: The 11th at the same time?

MR. SKAGGS: That'd be great.

MS. HUGHES: Thank you all so very much for being able to do that.

MS. STECKEL: And the other thing is Sharley will now be your key contact, so we've had the TAC management kind of spread out every which way, and it was managed very well and everyone was doing a great job, but it's harder to coordinate when it's done that way. So Sharley will be your key contact. Anything that you need, reach out to her. She'll reach out to the subject matter experts when we get the agenda which will be due two weeks prior to the meeting. Changes

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can be made ten days, I think, ten days prior to the meeting.

MS. HUGHES: Seven to ten days.

MR. SKAGGS: We want to get the agenda out as quickly as possible because we like to have good discussion when we're here.

MS. STECKEL: Well, and I'm trying to be consistent with all the TACs so that everybody's hearing the same thing, and then Sharley and I and the executive staff will determine which Medicaid subject matter experts will be in attendance at the meeting. Okay. Thank you for making the one big change that we needed you to make.

MR. SKAGGS: Let me just say this, and I appreciate you reaching out and interrupting there a moment ago. This is very informal, please. You know, I've got -- I work -- I'm a Baptist preacher's kid, so I've got that gift of gab, and if I don't work from a script or something I've written down, I will be here all afternoon. You know, I've got some things I want to say, but this is a discussion. It's not -- it's not us just making our statements. It's, I mean,

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we want to be productive in this. We appreciate it.

Have you got the graphic? Wayne is passing out a 1-page graphic which shows rates of inflation over the past 10 years. As you can see from the handout, the Medicaid nursing facility price adjustment, which is noted in the blue line at the bottom, has fallen short of the inflationary adjustment paid by CMS or Medicare patients in the past.

The CMS inflation rate shown by the red line is the global insight CMS nursing home without capital market basket percentage. That's a lot of words. The inflation rate is for -- for the Medicaid has been one-tenth of 1% over the past five years falling short of meeting our labor and other direct and indirect patient costs.

Many providers across the state, I believe, we are in a state of crisis and we're trying to retain quality employees while doing so while receiving these nominal inflationary adjustments paid by the state over the past five years. And, obviously, we're coming today to request a full

1 inflationary adjustment to be paid July 1,
2 and I know you all won't address that or
3 can't address it today in full, but that's
4 the ask going in to today.

5 And I'll just say this, you know, we've
6 got -- one-tenth of 1% increase in 65 to 75%
7 of our overall revenue picture when we're
8 having to pay 1 to 5% increases in wage to be
9 able to keep up with the hospitals, to even
10 be able to keep up with McDonald's in a lot
11 of our smaller communities, and, you know,
12 the rates have not been rebased in 10 plus
13 years and current rates are just not
14 supporting the increases that we're seeing,
15 not only on the wage side which is 60, 70% of
16 our overall cost, but we've got -- it's on
17 the agenda. We've got liability cost
18 increases and things that we have no control
19 over due to the issues here in Kentucky, and
20 we're not keeping up. So I again ask for
21 July 1 would be that the Cabinet consider a
22 full inflationary adjustment to the Medicaid
23 rates.

24 Anybody want to chime in?

25 MR. TRUMB0: Yeah. The question is

1 is at what point does this become Medicaid's
2 fault when quality care can't be delivered
3 anymore? You know, I mean, when do we cross
4 over to that -- I mean, providers are doing
5 all they can, but our revenues are fixed. I
6 mean, we get whatever Medicare gives us. We
7 get whatever Medicaid gives us. The little
8 bit of private paid that nursing homes have
9 in this day and age, there's no incremental
10 margin there. So we're kind of on a downhill
11 spiral here, and, I mean, you want quality
12 for your customers. They're our customers,
13 too. But at some point, we have to agree
14 that we can't sustain. So that's the hard
15 question that we have is what can we do?

16 MS. STECKEL: Well, and
17 unfortunately, I have not had time to look at
18 -- I know we had scheduled and then I had to
19 reschedule in some time to learn about the
20 nursing home reimbursement except for fair
21 rental which I refuse to even think about
22 because my brain won't accept it. For some
23 reason, I am not capable of learning fair
24 rental. But the other stuff, I'm really
25 capable of. I don't know if any of you all

1 know, I used to work and actually own part of
2 nursing homes in Alabama, so I've worked in
3 long-term care. I've been on the floors
4 scrubbing underneath the kitchen tray and
5 from everything up from there, so I know what
6 you guys are going through.

7 I haven't had a chance, yet, to go into
8 the reimbursement, and that's what I need to
9 do, and working with Lee and with Steve, to
10 see where we are, what's the base line, and
11 what we need to do to move forward. Okay.
12 And knowing it's an urgent issue.

13 MR. TRUMBO: I mean, is Medicaid
14 able to do something to help end this
15 process?

16 MS. STECKEL: I don't know --
17 July 1st would be an issue of how we change
18 the budget in a biennium, and the budget is
19 set. So we'd have to come up with revenue to
20 -- we'd have to figure out where the revenue
21 would come to pay for it. So, no, without
22 revenue.

23 MR. SKAGGS: So in the budgeting
24 process, no increase was scheduled?

25 MS. STECKEL: Well, there isn't a

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budgeting process for this year. Steve, do you want to address this?

MR. BECHTEL: So when we did the biennium budget, I did put an increase in there to allow for our budget, but as you know, our budget was the 2018, but what we got funded was not what I put into the budget projections. What we were funded with the 2018 minus 6.65 percent. So regardless of what I put into our budgeting format and budgeting projections, that's all I got reimbursed or got funded. So now I've got to figure out, not just nursing facilities, but hospitals and physicians. I've got to make sure all those fit, that square peg fits in that round hole. So that's the dilemma that we have.

Now, we are looking at our budget forecast right now, as you know. We, if I may say, we did go out and state that we were about \$290 million shortfall over the biennium. Now, that's not a true shortfall. It's what did our consensus forecast -- what did we forecast that was going to be needed in expenditures and in funding minus what we

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received in the 2018 minus 6.25, and that was the \$290 million shortfall.

We had since had some decrease in enrollment. Our enrollment's gone down since May, or April or May. It went down 50,000 people that we've seen.

Now, what that does is it's not more for you guys, but it lowers our cap payment to the MCO's because that's what drives the MCO cap payment is enrollment. So as that goes down, we're not maybe not -- I'm trying not to get in the weeds on you here, Lee, but when those enrollments go down, you have a less MCO payment which allows us extra funds there to maneuver within.

So we will consider the -- what I present, and I haven't talked with you about it, yet, but what we present to the sitting commissioner every year is we give what is the rate's going to be, what would be the overall spin from the nursing facilities if we do it at the full inflationary, if we do it at 75% of the inflationary, 50%, 25%, and so on. And when I hand that to the Commissioner, they make a decision and then

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they tell us what -- so, unfortunately, the last five years, they told me to keep it at the .1, because of the budget situation where we found ourselves in.

So if we can fit it, you know, and if it fits our other agenda items, we'll definitely consider it. I hope that doesn't get too far in the weeds for you guys, but I'm maybe talking more to Wayne than anybody.

MS. STECKEL: So I may have misspoken because I didn't think there was an opportunity to look at the budget this biennium, this year in the biennium. So it sounds like there is. The last thing we want is businesses to go out of business, especially -- or provide substandard quality of care because what we're not, or are, paying.

So let us get further down, plus we were looking at a scary budget number, and now it looks, thanks to a variety of fortuitous circumstances, that we may not be doing as poorly as we thought. So I can't give you an answer today, but I can tell you we'll look at it.

1 MR. BECHTEL: And the other thing,
2 if I may, I did reach out to Wayne -- when
3 was that -- three, four weeks ago and advised
4 him if you all wanted to look at another
5 provider tax, you know, increase in provider
6 tax, I will caution you that CMS is really
7 coming down hard on those now here recently.
8 But if they wanted to, we'd looked at this
9 every year in the last past years. We said,
10 no, we're not going to do it. But if we have
11 the mechanism to do that, I told Wayne if we
12 could come up with that proposal before
13 May -- it's been waiting until May because we
14 have to do it before June 1st because it has
15 to be over at Revenue before June 1st in
16 order to have it in place on July 1st. But
17 that's something that we could reach out to.
18 But the reason I reached out to him was for
19 that purpose of maybe if we didn't have a way
20 to fund it, maybe we could look at having
21 that revenue coming in from the provider tax.

22 MR. SKAGGS: Obviously, as a
23 provider, we would prefer not -- that the
24 monies come, you know, from the Cabinet.

25 Now, it's my understanding that the

1 provider tax increases that we have -- or not
2 -- and I won't call them provider tax
3 increases. The provider tax funding that we
4 have thrown out in the past two or three
5 proposals that we've done are within the
6 current state health plan that basically we
7 are below the capitated rate within the
8 provider tax statute is my understanding, and
9 all we were attempting to do in that was to
10 basically bring it up to what the statute
11 allows, which as I understood it and correct
12 me if I'm wrong, as I understood it required
13 no CMS input at all as long as we were within
14 the approved statutory amount.

15 MR. BECHTEL: For those three, I
16 call them silos, but three different silos.

17 MR. SKAGGS: Yes. As long as we
18 stayed within those and it was a uniform
19 adjustment that that didn't require CMS to do
20 much of anything. Correct me if I'm wrong.

21 MS. STECKEL: I think we would
22 still have to do a state plan. Even the
23 percentage would be -- but it's a lot easier
24 -- to your point, it would be a lot easier if
25 we made no substantive changes to the policy,

1 but we're just increasing the amount. But
2 independent of the provider specific taxes,
3 I'd like to get back to having somebody,
4 Wayne and his team, but somebody come in and
5 help me understand the way we currently
6 reimburse because the other question I would
7 put on the table is are there --
8 understanding that the pie has to be bigger,
9 so don't panic. Because I knew what your --
10 I know what your first response will be if I
11 hadn't said that, but are we paying nursing
12 homes as efficiently as we could or should?
13 So, you know, and I don't even have the
14 baseline to know how we're doing it now. So
15 I would also ask you all to think through are
16 there reimbursement methodologies, and I know
17 we're about to have to go through a new
18 change with the PDPM. See, I don't even know
19 all the acronyms, Dave. So as we move to
20 that, is there a way that we can both address
21 the historic shortfalls, but then be more
22 efficient in the way that we're paying?
23 I don't know the answer to that, and I
24 don't know whether it's yes or no, so but I
25 would ask that we be thinking through as we

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go through this agenda and as we move forward with nursing home reimbursement issues.

MR. SKAGGS: And I'll answer -- go ahead, Betsy.

MS. JOHNSON: By efficient, are you relating that to quality? What do you mean by efficient?

MS. STECKEL: Quality, and are we being efficient in that -- what I don't want to do -- quality is the number one. But then I also don't want to reward somebody for just spending money. So are we spending money and getting a value out of it? So and there are a lot of ways that that's been tested and tried and reimbursed in a variety of states, but --

MS. JOHNSON: And I'm not speaking about TAC, but I think we would like to spend money in order to improve quality. So I think that should be the ultimate goal, and whether that be in workforce or, you know, any kind of infrastructure changes or whatever. But clearly, as Jay outlined as far as the crisis situation we currently are in, there's been no money to spend toward

1 improving quality, especially around the
2 workforce issues. I mean, we're just not
3 competitive. We are just not competitive at
4 all. And so when you think about that, I
5 think you need to think about --

6 MS. STECKEL: I think we're
7 actually on the same wavelength. So for
8 instance, and, again, when I said earlier
9 that sometimes ideas will be thrown out and
10 they may be bad ideas, they may be good
11 ideas, but they're kernels. But for
12 instance, let's look at a reimbursement
13 system that rewards training and raises for
14 CNAs versus I'm just going to give you a \$2
15 per member per month pay raise. Do you see?

16 So I think we're on the same page. I'd
17 rather -- I'd rather target our spending than
18 just here's some money, I know you guys are
19 going to do good things, because you all may,
20 but you do know you have members that aren't.
21 So that's what I would like -- so I think
22 we're saying the same thing.

23 MS. JOHNSON: I think we are, yeah.

24 MR. TRUMBO: Sounds like you're
25 wanting to -- we're actually reimbursed on a

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per diem. It's not based on membership. So, you know, they have to have gotten service for us to get paid.

MS. STECKEL: Right.

MR. TRUMBO: And so the efficiency of that, I mean, I don't know if there's a whole lot more efficient way to do that, but to your point about quality, we have seen other states that have portions of the rate attributed to quality services and that those providers that demonstrate those things are able to get those funds, which I think kind of goes to what you would like to see.

MS. STECKEL: Yeah. And I think even with the per diem rate, there are incentives for efficiency that you can put into the system, so and it's just a matter of us working through it. And I know it's on the agenda for later, but the PDPM issue, we've got to deal with it. I need to be up to speed on it. Our folks are learning about it and how -- so, one, how does that impact -- we're going to have to do it, how does it impact it, and then this issue of the reimbursement rate underneath that. At the

1 time we're doing the PDPM 10 we then do --
2 I'm almost constitutionally not able to say a
3 raise, but increase of reimbursement in such
4 a way that it accomplishes what we're talking
5 about here. So does that make sense?

6 MR. SKAGGS: Uh-huh. Well, and
7 kind of going on what you all've already
8 discussed, I mean, the incentive in our
9 current program, we're a case make system so
10 the higher acuity residents we are able to
11 take on and care for, the better our
12 reimbursement is. You know, but you get in a
13 catch 22 situation in that if you can't get
14 the staff in the building to be able to staff
15 up then you can't take on those higher
16 acuities. Then you all start hearing from
17 the hospitals because the hospitals have got
18 these extreme high acuity folks in beds that
19 they can't find placement for.

20 You know, so it's a system that can be
21 tweaked, I agree. There are ways to do it,
22 but what I'm seeing in other states is when
23 they are doing this type of conversion and
24 starting anew, you've got to fully fund it
25 anew, you know, and to get away from the

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one-tenth of 1%, where we're behind, you've got to fully fund it anew, jump off from there.

MS. STECKEL: Got you. Yeah, and that's why I said I understand the pie needs to be bigger. Wayne, if you wouldn't mind, I'm going to have Sharley work with Donna and get you back on my calendar to help --

MS. JOHNSON: We're back on your calendar.

MS. STECKEL: Are you? Okay. Good. To help me learn about the reimbursement.

MR. JOHNSON: 22nd, I think.

MS. STECKEL: Perfect. Perfect. So that will be helpful just, much to the dismay of some of my folks, I'd like to get in the weeds on certain things, and this is one of them that I'd like to get in the weeds on. So I need to know what we do now and understand it better in a very detailed way, but I hear what you're saying and agree.

MR. SKAGGS: All right. Anything else on -- great discussion. I appreciate that. Liability costs. In July of '18 the

1 association testified in a Medicaid oversight
2 committee meeting that nursing facility
3 professional liability rates have increased
4 drastically over the past ten years. TAC
5 member Jay Trumbo was at the table during the
6 meeting, and he stated that liability premium
7 cost increases have almost crippled several
8 facilities resulting in two providers filing
9 for bankruptcy protection, and a nonprofit
10 facility dropping liability coverage entirely
11 and going bare. The association conducted a
12 general and professional liability survey of
13 its members in the Spring of 2018. I think
14 Wayne is handing that out at the current
15 time. And I will say I'm disappointed in the
16 number of the participants, but the
17 freestanding nursing facilities provided that
18 responded to the survey have seen a 47 and a
19 half percent year over year annual increase
20 in their liability costs. As you know, in
21 the past several years, we've attempted to
22 work through the legislature on tort reform.
23 We worked on the medical review panels which
24 have been struck down as unconstitutional.
25 There have been some other bills that have

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been introduced. These costs can't continue to be borne by nursing facility providers much longer.

We're looking to see does the Department have any thoughts on the liability costs and would you support potential legislation like on an affidavit of merit or something along those lines that might ease our burdens? And let me just tell you this, we work with -- March 1 was our renewal this past year. We have a facility that has had no liability claims. They've had -- they're a 5-star facility. They're off the charts on the staffing. And just because of the State of Kentucky, and lack of tort reform, our liability insurance cost rates, or rates, tripled this past year. I'm talking -- it's a small facility, but we're talking 45,000 to about 140,000 in a one-year -- and the thing about it is with these liability companies, they ask for all that money up front. There's no quarterly payment, monthly payment like you do with your automobile insurance and your home insurance.

Worked with another facility that had

1 one claim. You know, it had not gone to
2 trial. It's just a claim, but it's a claim
3 with -- you've seen the name -- Wilkes &
4 McHugh. Because of the Wilkes & McHugh, the
5 liability insurance companies go nuts. They
6 think they're going to have a big settlement.
7 This particular facility went from 90,000 a
8 year -- it's a larger facility -- 90,000 a
9 year in overall liability costs to 650,000 in
10 a one-year jump. That's money that we need
11 to be paying staff to provide quality care in
12 that building, and it's not money that we can
13 just go out and find. As I indicated, 65 to
14 75% of their residents are Medicaid. They
15 got a one-tenth of 1% increase. They're an
16 average case mix facility. So, you know,
17 they're not taking care of the highest
18 acuity, they're not taking care of the lowest
19 acuity. They're right in that midline.

20 But what we're hearing going into
21 March 19th renewals is that even though
22 there's been no claims on either one of those
23 buildings, we're facing anywhere from 40% to
24 100% increase over what we're currently
25 running. And, again, no claims at all.

1 We're being told by the agents it is 110%
2 market-driven. The insurance companies are
3 saying, We don't want to do business in
4 Kentucky, but we've got to do business in
5 Kentucky, therefore we'll charge the premium
6 necessary to do business in Kentucky, knowing
7 that Kentucky hasn't done any -- made any
8 efforts to work reform.

9 So, again, we are going to the
10 legislature. Betsy, I know you're waiting,
11 and I appreciate it. She tempers me. She
12 does. She gets me off of my pedestal and
13 speaks.

14 MS. JOHNSON: I'm very passionate
15 about this.

16 MR. SKAGGS: You made it to the
17 8th.

18 MS. JOHNSON: Do you mind if I read
19 the e-mail that I received between Christmas
20 and New Years that I shared with you?

21 MR. SKAGGS: Please, share that.
22 Absolutely.

23 MS. JOHNSON: So this is from a
24 member who's based out of Utah, and they do
25 business across the country, and they're

1 fairly new to Kentucky, I think a year after
2 I started. So they've been -- I think 2015.
3 So they're fairly new to Kentucky. But so:
4 "It's me again. Hope you're well. I'm
5 reaching out to let you know we have seen a
6 tremendous spike in premiums for PLGL
7 coverage. We had one of Joseph's facilities
8 still on traditional policy and we just
9 received their quote today."

10 Joseph being their regional guy that's
11 got their Kentucky guy.

12 "We just received their quote today for
13 2019. 7,850.00 per bed per coverage. We'll
14 be moving it into our high deductible
15 offshore program, but that doesn't mean this
16 will be a long-term or satisfactory solution.
17 The premium costs are driven by the claims
18 and frequency. Whether we get a traditional
19 insurer or high deductible program, these
20 kind of expenses just can't be sustained much
21 longer by the industry. Best and happy new
22 year."

23 And that is just one of many e-mails and
24 calls that I received. I know Wayne receives
25 more than I do. So it isn't just the people

1 on this committee. It's a statewide problem.
2 And just to let you know, I've reached out to
3 Dr. Alvarado who is now, as you know, a chair
4 of Health and Welfare, he's very passionate
5 about this issue. I need to follow up with
6 him, but I believe he'll be willing to have a
7 committee hearing on this whether it be
8 during the session or during the interim.
9 It's going to be something we'll be talking
10 more publicly about because it's simply not
11 sustainable.

12 MR. JOHNSON: I was just going to
13 say in light of the survey that we did just
14 because it looks like there's very few, but
15 the corporates actually self-insure, so
16 really what we were looking at doing is
17 really targeting the single facilities and
18 that's really what the survey was. So even
19 though it looks like there's a small number,
20 we weren't cherry-picking the most extreme
21 examples or anything. It was simply the
22 single facility that responded that are
23 paying your conventional, you know, general
24 and professional liability premium, you know,
25 premiums each year.

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MS. STECKEL: So how is this represented in the cost reports or in the reimbursement methodology?

MR. JOHNSON: How is it?

MS. STECKEL: Uh-huh.

MR. JOHNSON: Commissioner, it's only reflected if there's a rebasing. So 2008, which was the last time that it was rebased, that would have been when --

MS. STECKEL: The cost incurred at that time. Got you.

MR. JOHNSON: Right.

MR. SKAGGS: And the increases that we're talking about have been incurring over about the last three to four years.

MS. STECKEL: Sure.

MR. SKAGGS: Realistically.

MR. TRUMBO: This chart also is not showing the providers that have dropped coverage that have gone to zero coverage. Well, the good news is they're not paying a premium. The bad news is if they get a bad enough lawsuit, they'll just hand the keys over. That's just not -- that's not a healthy way to do business.

1 MR. SKAGGS: Well, we work with a
2 county facility down in south central
3 Kentucky that just got their quote in. It
4 looked bad, as far as I was concerned. I
5 mean, it was about a 25% increase, and that's
6 about what we anticipated. But the
7 negotiating point with this particular
8 facility is, okay, we've got you in a
9 situation where you're a zero deductible
10 provider. For this 25% increase, you get a
11 \$50,000.00 deductible next year per claim.
12 Okay? So, you know, you've gotten about
13 \$20,000.00 worth of increase in the overall
14 premium, but one claim means it's 70,000, two
15 claims it's a 120,000, etcetera, etcetera.

16 They came back to us and said, We'll cut
17 it to 10% if you go to \$100,000.00
18 deductible. And I'm doing the math on it and
19 I'm thinking, okay, so we save 10,000, but
20 every potential claim that's out there, even
21 though we don't anticipate any, every
22 potential claim that's out there costs us
23 \$100,000.00 up front. You know, that's the
24 environment that we're working with.

25 MS. STECKEL: Sure. Tell me what

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you all do in risk management, how aggressive is your risk management program, particularly for those types of facilities?

MR. SKAGGS: I'll tell you ours is extreme because it's dictated by our insurance companies. Most of the liability carriers in the state even write you, you've got to participate in their risk management program. You've got to allow them to come in and do the front end training, and then you've got to follow certain protocols throughout the year to assure that you are mitigating the risk.

MS. LEHMAN: And they also come in and audit your policies and procedures to make sure that you've got everything up to their standards for regular, operational needs.

MR. SKAGGS: So especially for the independent owners like us, our risk management, even though we had risk management in place, it's being dictated at a higher level by the insurance companies who are willing to write us.

MS. STECKEL: Sure. Exactly.

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LEWANDOWSKI: And my facility just recently went through that, and we are one of the organizations that operate, you know, in a different state. So I mean, my per bed is \$1,000.00 in Kentucky, versus the state just north of us is \$250.00.

MS. JOHNSON: Just to let you know that statistics from -- I did share that with the house republican caucus. They gave us the opportunity to speak back in December about some of the pressure points on our profession, and so I shared their specific example of just across the river in Ohio, the significant difference in the premiums. Again, we're going to be talking about that a lot in the coming year.

MR. SKAGGS: The legislature is very aware of this. I mean, we tell it to everyone that will listen to us at this point. There's got to be some kind of relief, and the only way we can get it is through the legislature. We understand that. This year our focus -- I mean, obviously we'd like to go full tort, etcetera, etcetera, but our focus is the certificate of -- or an

1 affidavit of merit, whichever case it may be.
2 MS. STECKEL: Can you explain that?
3 MR. SKAGGS: That's what I was
4 going to do. I mentioned Wilkes & McHugh,
5 and you kind of shook your head, no.
6 MS. STECKEL: I'm not familiar with
7 them. Is it a lawyer --
8 MR. SKAGGS: They're a Florida
9 based organization.
10 MS. STECKEL: Oh, got to love
11 Florida.
12 MR. SKAGGS: They're a Florida
13 based organization.
14 MR. TRUMBO: They're a cousin of
15 Morgan & Morgan.
16 MR. SKAGGS: They're just not for
17 the people. They're for themselves.
18 MS. STECKEL: Well, I hate to tell
19 you, Morgan & Morgan --
20 MR. SKAGGS: They're not for the
21 people, either. Yeah. But when you get an
22 inquiry from Wilkes & McHugh, it's about 100
23 pages thick. It alleges everything but
24 nothing specific. I mean, they say that
25 their rights have been violated, their

1 dignity has been violated, but they never
2 come down to saying what standard of care has
3 been breached. And that's what -- that's
4 what's concerning to the insurance companies
5 is that, and fortunately our Supreme Court
6 has now said that resident rights is not
7 something -- is that right?

8 MS. JOHNSON: You want me -- yeah.

9 MR. SKAGGS: Please.

10 MS. JOHNSON: Now I'm really going
11 to get into the weeds.

12 MR. SKAGGS: It's important.

13 MS. JOHNSON: It is very important.
14 We're just sued differently -- we're just --
15 the trial attorneys attack us very
16 differently than they do other medical
17 professionals.

18 MS. STECKEL: One of the things I
19 did was coordinate the legal actions, even
20 though I'm not a lawyer, for the company. We
21 had 18 nursing homes, so I --

22 MS. JOHNSON: Yeah. Everything
23 from the full-page ads to these guys being
24 inundated with records requests. The OIG
25 within this Cabinet will tell you that they

1 get calls from attorneys all the time trying
2 to get information. They encourage people to
3 file a complaint with OIG first, let the OIG
4 do the investigation, and then they take that
5 information and they build some sort of case
6 that may or may not have merit. And I will
7 tell you, I mean, things happen in nursing
8 facilities, and just like they happen in the
9 operating room and elsewhere, and
10 professionals who make mistakes should be
11 held accountable. I mean, I think everybody
12 in this room would agree with that. But we
13 are just targeted in a different way.

14 So I think the Supreme Court has
15 actually provided us an opportunity in their
16 medical review panel's opinion because what
17 they said was a medical review panel
18 legislation applied broadly to negligent
19 cases which is found in common law and with
20 regard to those rights found in common law
21 you cannot deny access to the court system
22 under Section 14 of the Kentucky
23 Constitution. But residents' rights, as you
24 may or may not know, is a statutorily created
25 right for those who are residing in nursing

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facilities or -- yeah, they have to actually be residing in the nursing facility. That's another Kentucky Supreme Court that was in our favor.

So I think we're also going to be looking at some legislation that can put some unique protections for nursing facilities knowing that we are, and I know, you know, people won't believe us, but we are unfairly targeted every single day, which feeds into every other on this agenda item. Because can you imagine living in Wolfe County and you're working in that nursing facility, which is probably the largest employer in that county, but you have to open up your local newspaper and see a full-page ad saying that you're killing old people? I mean, wouldn't you rather go work at McDonald's or the Dairy Queen that's right around the corner?

So I mean, this environment that we have in Kentucky, and with the flat Medicaid rate is -- it has created a significant crisis for our profession. So that's a lot of legalese, but I do think there's some opportunity there to look at residents' rights and how we are

1 sued differently than physicians and
2 hospitals and other medical providers to
3 figure out if we can build up to, you know,
4 protection. I think everybody in this room
5 would agree, and I'm not an attorney and I'm
6 all about access to the courts, but we need
7 to figure out, you know, these Morgan &
8 Morgan, Wilkes & McHugh's who know if they
9 just start inundating with them records
10 requests, there's going to be a check written
11 because they don't have the time, the energy,
12 or the money to fight. That's a broken
13 system because that's your all's money going
14 to John Morgan who has a big jet parked down
15 in Florida. It's not going back into, you
16 know, care for these residents. So I'm going
17 to get off my soapbox.

18 MS. STECKEL: I don't know that
19 you've talked to the folks at Alabama's
20 nursing home association because it's about
21 -- gosh, it's been a while now. We went
22 through a very aggressive effort, the
23 association, and they -- I lovingly refer to
24 it as the boys, the big companies, the
25 Alabama companies, and made a bunch of

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changes.

MS. JOHNSON: I actually haven't.

MS. STECKEL: So you may want to --
I'll get you some contact information if
you're interested, but --

MS. JOHNSON: Okay.

MS. STECKEL: Including, you know,
how -- what they could ask for in a records
request, and I mean, it was pretty extensive.

MR. SKAGGS: And I'm a layman, I'm
not a lawyer, but my understanding on the
affidavit of merit is they have to actually
state in their action what the breach is.
You know, and that's what we're looking for
support on. You know, I don't think that
support on something like that would cost the
Cabinet anything, and obviously it would help
us from our end on controlling costs,
etcetera. I honestly think, and I'll retire
before it ever happens, but I honestly think
that without tort reform, what we've seen in
the last year to two, is the independents
like myself can't afford to do business
anymore, and we're selling out, and you're
selling out to large out-of-state

1 corporations. They're buying them out up.
2 They're pulling in management companies that
3 -- you've read the newspapers. Yeah, so
4 sometimes the management companies they hire
5 don't have the best reputations in other
6 states. They're betting on the boomers
7 turning 75 in 2020. They're betting on the
8 fact that by 2025 they can unload and they
9 can walk away with a lot of money.

10 What we're seeing and hearing is that
11 there are companies coming in, not only to
12 Kentucky, but to other states and making
13 these purchases who don't provide quality
14 care. They know that they've got fixed
15 reimbursement, therefore the only way that
16 they can be profitable like they want to be
17 is to cut costs. And when 65% of your costs
18 are labor, that's the first place they start
19 looking. Yeah, they can squeeze the vendors
20 out here for an extra 2 or 3%, but, you know,
21 that's not going to make a profit margin
22 they're looking for when they're coming in
23 and buying up facilities in Kentucky.

24 Unfortunately, over the past couple of
25 years, the small operators like us have

1 reached a point where we can't operate.
2 We're selling out to these guys, and then we
3 start hearing from past employees as to what
4 they're dealing with now under new ownership,
5 new scenario. We don't want that for the
6 residents of Kentucky. We want to be able to
7 operate or provide that -- we think personal
8 care that we give as a small, independent
9 provider that many times you don't get with
10 the big corporations. But without some
11 relief somewhere, you know, that's where we
12 are.

13 MS. STECKEL: Betsy, can you get me
14 some information so that I can share this
15 with Hans, our lawyers, and with Adam, who's
16 also a lawyer. Based on what you said, I
17 don't think we would have a problem
18 supporting it, but it would need -- I need to
19 run this through. So if you could just get
20 me --

21 MS. JOHNSON: I'd be happy to.

22 MS. STECKEL: -- some information
23 about it. I want to make sure -- I only play
24 a lawyer on TV.

25 MS. JOHNSON: I think it's

1 important for us to be very transparent in
2 what we're going to be trying to pursue in
3 this legislative session because I know you
4 all will get questions, your government
5 relations folks when they go over there in
6 the hallways, but these are -- these are
7 pressure points, and in the end, as Medicaid
8 contractors, we're trying to protect the
9 money just as much as you all are, make sure
10 it's going back to resident care, and that's
11 why we're pursuing the legislative agenda
12 we're pursuing in the session.

13 MS. STECKEL: I know exactly what
14 you're saying and exactly the problems you're
15 going through, you know, and not to be tried
16 with been there done that, so I hear you, and
17 we would want to help in any way that we can
18 as long as there was a commiserate and you've
19 answered that, but with the risk management,
20 the quality programs, and that -- you know, a
21 bad actor is a bad actor. But I had one
22 lawsuit, a loss of consortium for a person
23 and it never graced the doors of the nursing
24 home of her partner the entire time, the
25 entire 10 or 12 years that he was there. So,

1 you know, and that's just the tip of the
2 iceberg. So I'm know I'm preaching to the
3 choir, but I hear you and know because I've
4 been there.

5 So let me see, but I do -- in this case
6 I'm not comfortable just saying absolutely we
7 can support the affidavit of merit, but if
8 our lawyers and the Secretary agrees, then
9 we'll come back and support it.

10 MS. JOHNSON: Okay. Thank you.

11 MS. HUGHES: Now, Betsy, we have
12 size limits on how much you can put in an
13 e-mail.

14 MR. SKAGGS: Hand-delivered.

15 MS. JOHNSON: I was thinking a
16 one-pager.

17 MS. STECKEL: Thank you. Yeah,
18 we'll be glad to look at that. That makes
19 perfect sense.

20 MR. SKAGGS: Excellent. Wayne, I
21 know -- do you have the summary of CMP costs
22 that was on the agenda?

23 MR. JOHNSON: No, I don't have a
24 summary.

25 MS. STECKEL: Well, but that's one

1 of the things -- I know we've got one project
2 that I've signed off on to use the CMP money
3 for some workforce development. There's a
4 lot of money in that pool.

5 MS. JOHNSON: 32 million. Again,
6 that's Medicaid dollars, you know. Share of
7 it has to be Medicaid dollars. I can give a
8 brief summary of what's happening on that
9 survey.

10 MR. SKAGGS: Please.

11 MS. JOHNSON: You know, when I
12 started this job in 2014, and the only thing
13 anybody wanted to talk about was the survey
14 environment in Kentucky. And, you know,
15 well, it was -- the litigation environment
16 and survey environment. And so at that
17 point, the Chair of our association said,
18 Let's create a task force to look at because
19 we can't just go to Frankfort complaining.
20 We have to have some data.

21 So sure enough, we worked with American
22 Healthcare Association, our national
23 association, and we have a fantastic research
24 department. And lo and behold, yes, this
25 environment is bad.

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MS. STECKEL: It's Region 4.

MS. JOHNSON: Yeah, Region 4 is the worst in the country, and then Kentucky is the worst in Region 4.

MS. STECKEL: Wow.

MS. JOHNSON: So we, back then and currently, back then being 2014, we are number one in the nation and number one in Region 4 for the amount of CMP's being assessed against our facilities. Although the amount of citations being issued against or deficiencies being found against a facility that is not the most when they are cited is typically the very severe and most severe, immediate jeopardy. So we are number one in the amount of CMP's being assessed, and number one of IJ's being issued against our facilities.

So then that begs the question, well, maybe we just have really poor quality facilities in this state, so we had to look at that, as well. And would I say we're the best? No. But are we an outlier as regard to the worst? No. We are solidly in the middle, and I think everybody on the TAC

1 committee will tell you we want to improve.
2 We want to change that needle, but without --
3 with a flat Medicaid rate and workforce
4 issues, being sued all the time, just all the
5 pressures, it's almost impossible to focus on
6 quality. And, also, when you have surveyors
7 constantly in your building, because -- and I
8 have some theories I'm going to keep to
9 myself here if I can, but, you know, we feel
10 like there's something, you know, I think
11 your sister agency and the OIG has some work
12 to do. I'm going to be with the Region 4
13 folks on Tuesday, and I plan on speaking my
14 mind to them. This is a problem with all the
15 Region 4 associations. We're all together,
16 but I'm in the worst situation leading this
17 association. And so, you know, regulating a
18 nursing facility is very important. It
19 assures that everybody is doing what they
20 should do. We're taking Medicare/Medicaid
21 dollars, we understand the government has to
22 have oversight, but it should be an
23 environment that, again, encourages quality
24 and rather it being the punitive environment
25 that we are feeling because I can tell you I

1 woke up to a text on Saturday morning from a
2 facility where there was a complaint about a
3 missing linen. It turned into a 4-day
4 complaint survey. They dug and dug and dug
5 and could not find any unsubstantiated
6 complaint about the linen. They found
7 something else. I think if anybody else were
8 watched for that long you're going to find
9 something wrong with what they're doing.
10 We're all human, right?

11 So they ended up getting a deficiency,
12 and, you know, what is that -- how is that
13 improving the quality of those residents'
14 lives? I don't see it. And then there's
15 much more or worse examples.

16 And so recently we took this data, the
17 most recent data we have, including \$32
18 million in the CMP fund, and talked to
19 Secretary Brinkman about it. That was in
20 December. He seemed very concerned about the
21 data he saw. I don't know if it'll result in
22 anything, but we might be pursuing
23 legislation, too, that looks at, to the
24 extent that the state can control the survey
25 process to see how surveyors are trained, to

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make sure there's not conflicts of interest among those surveyors, and that we're all working toward the same common goal which is to care for those residents in the best way we can.

So, again, I think that's just a highlight. When you're fining facilities that much and they're writing those checks that'd be put in that fund, that's not money coming back to resident care, and it's -- I'm very happy to hear that you signed off on that CMP grant. We have been working on this for two years. We really think that money would be well used by trying to encourage people to join the workforce in long-term care as their career path. It's a true calling, and it's not for everybody, but if we can get the word out there and get people right of high school to become a CNA, you know, I think that's important. So that's how that relates, and it's just another pressure on our profession.

MS. STECKEL: Well, and with \$32 million, there's a lot of programs that we could do focused on quality.

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MS. JOHNSON: Yes.

MS. LEHMAN: And one other thing, if I could, working off what Betsy just said, it's a vicious cycle because these surveys are out there now for everybody to look at, a nursing home compare, and that's where administrators are going. They have full-time people doing nothing but reviewing the survey, and that's where all of our lawsuits are coming from. I mean, all you have to do is have something written in the deficiency whether true or not, whether it was an immediate jeopardy or not. And I'm a legal nurse consultant as well, as part of our risk management, and I'm seeing lawsuits just unbelievably based on a survey that really didn't have any merit to it.

MS. STECKEL: The lawyers don't even have to do any work.

MR. SKAGGS: That's correct.

MS. STECKEL: Okay. I'd like to work -- I know that that's out of the OIG, that pool of money, but whatever I can do to work with Steve to see how we can start bringing up some of that for quality

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investments.

MR. SKAGGS: Thanks, Betsy.

Appreciate it. The third item on the agenda is RUG III after PDPM. Originally, in the last TAC meeting, we did discuss the PDPM implementation. I think we surprised you with it. But since then, we've gotten an update that Myers and Stauffer might be able to address the Department's support for continuing RUG III through September of 2020. I know for sure it would be less costly for providers. I think it would be less costly for the state if we could continue to use RUG III going through that 2020 date. And I guess the question on the table at this point in time is could we avoid upgrading to RUG IV, and is that something that could be considered going with RUG III through 2020.

MR. JOHNSON: Terry, CMS has agreed -- you may know this, but they have agreed to support RUGs through September 30th of 2020. That's why that date. So that was something -- I think it was an open door forum called that CMS had in December when they had that announcement. So that's why they --

1 MR. SKAGGS: Okay. I'm working
2 from my notes. It's always good to have you
3 in the room.

4 MS. STECKEL: Let us look at this
5 and see what we can do.

6 MR. SKAGGS: You know, one of the
7 things that we -- when we started going to
8 PDPM, trust me, we're going constantly to
9 these PDPMs. I've heard the same thing over
10 and over five or six times now, and the thing
11 about it is I learned something new every
12 time I go into one of these. But the one
13 thing from our Medicaid experts that we've
14 utilized when we worked on reimbursement
15 issues with the Cabinet in the past, is that
16 going to PDPM our risk is greater on the
17 crossover back to Medicaid than it probably
18 is on what we've got to do to maintain our
19 reimbursement or improve our reimbursement on
20 the Medicare side. It's that crosswalk from
21 the Medicare MDS down to Medicaid that
22 probably gives us the greatest risk. And
23 maintaining that RUG III system as is, going
24 forward with CMS being willing to support it,
25 we feel like it's the best way to go.

1 MR. TRUMBO: Least amount of change
2 in a world of change.

3 MR. SKAGGS: Yeah. PDM is going to
4 be huge for nursing facility providers. I
5 mean, it's a completely different mindset
6 going in. It's not going to be delayed.
7 It's going to be in place October 1 of this
8 year, and like I say, we're training
9 constantly on it now.

10 MR. TRUMBO: Shift away from
11 therapy?

12 MR. SKAGGS: Yeah, yeah.

13 MS. STECKEL: Are we doing training
14 for our folks?

15 MS. GUICE: The training is being
16 offered by CMS or the learning
17 collaborations.

18 MS. STECKEL: Are our folks
19 participating in all of that?

20 MS. GUICE: Yes.

21 MR. SKAGGS: For us, the PDPM side
22 of it is so huge that our national
23 association has developed the programs and
24 the training and is pushing them down the
25 state. So everything that we're getting --

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we're hearing the same thing that Alabama is and Ohio is, Indiana, etcetera. Anyone who participates in the American Healthcare Association has that opportunity for the same webinars, the same onsite trainings and all of that that we've got coming up.

MS. STECKEL: Is this through Mike Cheek?

MR. TRUMBO: Yeah, he's the trainer.

MS. STECKEL: I would call on one, too, but we've been closer friends, adversarial friends, closer friends, so depending on generally where I am. So but he's very, very good at what he does. Very, very good. Okay.

MR. SKAGGS: So at this point, we've gotten through what we had on the agenda, and I have written a couple notes here. At the meeting on the 22nd, Wayne is going to bring the information to help you understand our current --

MS. STECKEL: Teach me about reimbursement.

MR. SKAGGS: -- system. From the

1 liability side, you're going to provide her
2 with information on the affidavit of merit
3 and what we're looking at going forward. And
4 then we've got the question out to you
5 regarding the RUG III component.

6 MS. STECKEL: Perfect. This has
7 been a great meeting, and I hope we continue
8 like this. And I'll reach out to Tim Veno
9 about getting Leading Age involved in these
10 discussions, too, so that we can have a very
11 robust --

12 MR. SKAGGS: Well, as a profession,
13 we want to make sure that when we come and
14 sit down with the Cabinet, with the OIG, with
15 anyone that touches our profession, we want
16 to make sure that we're not saying one thing,
17 that they're not saying another thing. We've
18 been able in the past few months to bring
19 signature healthcare into our association.
20 At one point in time a couple years ago, it's
21 what Leading Age thought, what KCF thought,
22 and what Joe thought. Well, now Joe's
23 working with us at this point. We're
24 reaching out to Leading Age and trying to get
25 one voice as we come in because we're not

1 going to be productive if we don't. If we
2 come in with one voice, then we can stick to
3 the issue and hopefully resolve some issues.

4 MS. STECKEL: I agree. Anything,
5 Lee? Did I miss anything, or, Steve?

6 MS. GUICE: I don't think so.

7 MR. TRUMBO: Got any updates on
8 clocks or --

9 MR. SKAGGS: I know that's in the
10 wings, but --

11 MS. STECKEL: No. That's --
12 actually, that would be appropriate. So as
13 you all know, the -- and this doesn't affect
14 you all, but the co-pays went into effect on
15 January 1st. So we are not seeing
16 significant impact that everyone was
17 predicting so -- which is what we thought.

18 MR. TRUMBO: The sky has not quite
19 fallen?

20 MS. STECKEL: Correct. Correct.

21 MS. GUICE: Today.

22 MS. STECKEL: Today, yeah. I
23 should say knock on wood. The 1115 Kentucky
24 Health Waiver is going full tilt, the
25 implementation for April 1st. So we are

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looking forward to that and having that rolling on April 1st. Jill, would you like to give an update on the 1915(c)?

MS. HUNTER: Sure. Absolutely. We have in the 1915(c), we're doing a complete redesign. So we dropped all six of our waivers yesterday for public comment, so they're out for a 30-day public comment, and we'll be moving those forward in a -- very innocuous changes. This time they're very basic, getting definitions more in line, creating some consistency between the waivers, and then we'll be moving forward. We're also doing a complete rate study on the waiver side of things.

MS. STECKEL: Did I leave anything out? I think that's all we have going on with Medicaid. David, did I leave anything out with the Cabinet?

MR. GRAY: No.

MS. STECKEL: The only way we're going to be able to serve our beneficiaries is if we have more meetings like this, and I am open -- my door is always open, and I had a pharmacy TAC this morning and said the same

1 thing to them. My way of doing business is
2 if we've got an issue or we want to talk
3 about something, get everybody in the room,
4 and let's talk about it and work through it
5 because 95% of the time you can resolve it.
6 You may not get everything you want, I may
7 not get everything that I really wanted, but
8 we're serving the beneficiaries and we're
9 solving the problems.

10 There will be times we'll disagree, and
11 that's okay. That happens, and it is what it
12 is. But respecting each other, and talking
13 to each other, and working through issues is
14 what makes it work. So I am committed to
15 that. I think you know that the folks here
16 at Medicaid are committed to that. So
17 whatever we can do to continue, we're looking
18 forward to it. Thank you. This is exciting.

19 MR. SKAGGS: And we appreciate it.
20 I feel like, you know, I'm three hours from
21 here, and I feel like that I have --
22 sometimes when you drive up, you feel like
23 you've wasted your time. I don't feel that
24 way today. I feel like it's been very
25 productive, and appreciate the input, and

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we'll get you the information and look forward to the next meeting in April.

MS. STECKEL: Wonderful. Thank you all very much.

- - -

(Court Reporter's Note: At this time, the TAC Meeting went off the record. The motion to approve the last meeting's minutes was made, and by a unanimous vote, the Minutes were approved.)

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1 **REPORTER'S CERTIFICATE**

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3 STATE OF KENTUCKY)

4 COUNTY OF FRANKLIN)

5 I, Kathryn Marshall, Court Reporter and Notary
6 Public in and for the Commonwealth of Kentucky at
7 Large, do hereby certify that the foregoing
8 typewritten pages are a true and accurate transcript
9 of the proceedings to the best of my ability.

10 I further certify that I am not employed by,
11 related to, nor of counsel for any of the parties
12 herein, nor otherwise interested in the outcome of
13 this action.

14 IN WITNESS WHEREOF, I have affixed my
15 signature and seal this 16th day of January, 2019.

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21 _____
22 Kathryn Marshall, Court Reporter
23 Notary Public, State-at-Large
24 Notary ID 420146

25 My Commission Expires: August 3, 2019