CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAID ASSISTANCE

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Via Videoconference
May 25, 2023
Commencing at 10:03 a.m.

Shana W. Spencer, RPR, CRR
Court Reporter

APPEARANCES

ADVISORY COUNCIL MEMBERS:

Elizabeth Partin - Chair
Nina Eisner (not present)
Susan Stewart
Dr. Jerry Roberts
Dr. Garth Bobrowski - Co-chair
Dr. Steve Compton
Heather Smith
Dr. John Muller (not present)
Dr. Ashima Gupta
John Dadds (not present)
Dr. Catherine Hanna
Barry Martin
Kent Gilbert
Mackenzie Wallace (not present)
Annissa Franklin (not present)
Sheila Schuster
Bryan Proctor
Peggy Roark
Eric Wright

CHAIR PARTIN: We'll call the meeting to order. We need roll call, please.

MS. BICKERS: Okay. I have Beth Partin.

CHAIR PARTIN: Here.

MS. BICKERS: Nina Eisner?

(No response.)

MS. BICKERS: Susan Stewart?

(No response.)

MS. BICKERS: Jerry Roberts?

MR. ROBERTS: Here.

MS. BICKERS: Heather Smith?

(No response.)

MS. BICKERS: Garth Bobrowski?

DR. BOBROWSKI: Here.

MS. BICKERS: Steve Compton?

DR. COMPTON: Here.

MS. BICKERS: John Muller?

(No response.)

MS. BICKERS: Ashima Gupta?

DR. GUPTA: Here.

MS. BICKERS: John Dadds?

(No response.)

MS. BICKERS: Catherine Hanna?

(No response.)

MS. BICKERS: I think -- did I hear a "here"?

DR. HANNA: Here. Can you hear me?

MS. BICKERS: Okay. I did. Thank you. I thought I heard you. Sorry about that.

Barry Martin?

MR. MARTIN: Here.

MS. BICKERS: Kent Gilbert?

MR. GILBERT: Here.

MS. BICKERS: Mackenzie Wallace?

(No response.)

MS. BICKERS: Annissa Franklin?

(No response.)

CHAIR PARTIN: Sheila Schuster?

(No response.)

MS. BICKERS: Bryan Proctor?

MR. PROCTOR: Here.

MS. BICKERS: Peggy Roark?

(No response.)

MS. BICKERS: Eric Wright?

DR. WRIGHT: Here.

MS. BICKERS: Okay.

CHAIR PARTIN: Do we have a quorum?

MS. BICKERS: I was trying to count

as we went through. And I believe I saw Sheila log in. Sheila, did you say here?

DR. SCHUSTER: Yes, I did.

MS. BICKERS: There you are.

DR. SCHUSTER: Yeah. Thank you.

MR. MARTIN: And Heather Smith is here as well.

DR. WRIGHT: Yeah. I saw her. She made a note in the chat.

MS. BICKERS: Okay. I believe you have a quorum. Thank you. I was trying to count and call names at the same time. Thank you, guys.

DR. WRIGHT: Madam Chair, may I make a quick comment?

CHAIR PARTIN: Sure.

DR. WRIGHT: I know that I brought the other issue of the PDS legislative rate increase. I'm here at this meeting. I do want us to be able to have a conversation about that.

Unfortunately, I did have a conflict that's going to come up at 11:00 that may prohibit me from being in the meeting for about an hour. But I hope to be able to

rejoin after that. I just wanted to make sure you are aware of that.

CHAIR PARTIN: Okay. We can move that up on the agenda.

DR. WRIGHT: Thank you.

CHAIR PARTIN: Okay. So would somebody like to make a motion for approval of the minutes?

DR. BOBROWSKI: So moved.

DR. SCHUSTER: Second. This is Sheila Schuster.

CHAIR PARTIN: Any discussion?

(No response.)

CHAIR PARTIN: All in favor, say aye.

(Aye.)

CHAIR PARTIN: Anybody opposed?

(No response.)

CHAIR PARTIN: So moved. Thank you.

And, Erin, welcome back.

MS. BICKERS: Thank you. It's good to be back.

Oh, and it looks like in the chat, Peggy Roark has joined us.

CHAIR PARTIN: Great.

Okay. So under old business, what is the status of the Anthem MCO?

COMMISSIONER LEE: Good morning. I'm Lisa Lee, Medicaid commissioner. That is still in litigation so no update at this time.

CHAIR PARTIN: Okay. Do we have any idea how long that's going to go on?

COMMISSIONER LEE: Absolutely no idea how long it could go on. It is in the court system, so it's a little bit out of our hands. But if we hear any updates, we will definitely pass that along.

CHAIR PARTIN: Okay. I'll just keep it on the agenda.

And the last I heard, the letter to the governor regarding the workforce study was going to be sent, and has it been sent?

COMMISSIONER LEE: So I guess this is an example of where great minds think alike. You know, the report that you all had attached to the letter was actually provided to the University of Kentucky several months back, and they had been working on updating

that report. And we hope to have a first draft on July the 1 to share with this committee so that you all could read it and see if we need to do further work on that.

So that had been something that was in process, so we did share the letter with the secretary's office. But since we're already in the process of updating that report, we have not sent that to the governor's office.

CHAIR PARTIN: Okay. So we'll put that to the next meeting.

DR. SCHUSTER: May I ask a question? This is Sheila Schuster.

CHAIR PARTIN: Sure.

DR. SCHUSTER: Are they, I assume, Commissioner, using the same methodology that Deloitte did? And that is looking at the numbers that the licensure boards have.

COMMISSIONER LEE: Yeah. They are doing that and plus a few other things. We had a meeting yesterday, and they said that they hoped to have that report to us by July 1st. But before we put that out for public consumption, we would definitely like the MAC to take a look at that first and see if

there's anything else that we need to do in that report to kind of examine the workforce issues in the state.

DR. SCHUSTER: Yeah. Because my concern is that most of the licensure boards don't have accurate information.

COMMISSIONER LEE: Yeah. They are --

DR. SCHUSTER: I think the Board of Nursing is literally the only one that is asking the questions that need to be asked, you know. Are you working in your field? Are you working full-time or part-time? Where are you working? So they may have some other data sources. I don't know.

COMMISSIONER LEE: Yes. Yes. And we did give them the report, and they're using that as the basis to examine workforce studies. We had talked about the issues with the licensure board. We also talked about issues related to providers who may only be working part-time.

We also shared with them the results of the dental report that Dr. McKee and public health did, I think, last year. So we shared

those observations with them, also. So, again, hopefully have that by July 1st.

DR. SCHUSTER: Great. I appreciate that they're working on it already. I think that's fantastic. Thank you.

MR. ROBERTS: This is Roberts. Is this done through the public health -- a public health graduate program, or is it extension service? Or what department at UK is working on this?

COMMISSIONER LEE: So we have a contract with the University of Kentucky. They primarily do our data and analytics, and so it's part of that data and analytics team at the University of Kentucky. And they do have some graduate students working on the project.

CHAIR PARTIN: Okay. The next item is just a reminder that the maternal/child update will be at our July meeting and then the next item is a reminder that we will have an update on missed and cancelled appointments at our September meeting.

Next up is a presentation by DMS regarding providers pay tax for matching

funds.

MS. BICKERS: Steve, you should be a cohost and should be able to share your screen.

MR. BECHTEL: Okay. Can everyone see my screen here?

CHAIR PARTIN: I can't.

DR. SCHUSTER: Not yet.

MR. BECHTEL: All right. Hold on one second. Can you see it now?

DR. SCHUSTER: Yes.

CHAIR PARTIN: Yes.

MR. BECHTEL: Okay. So let me start my -- so my understanding is -- again, this is Steve Bechtel, chief financial officer for the Department for Medicaid Services.

I'm just going to give you a brief overview of the provider tax. And my understanding is the question in hand was somebody wanted to look to see how the provider tax is collected and then applied to a rate increase, if that is correct.

But let me just start off by just doing a brief summary of provider tax. CMS allows

states to generate our nonfederal share, which you hear a lot of us say "state share." That's what we're talking about, is this nonfederal share of our Medicaid expenditures. Eighty percent of our -- roughly, 80 percent of our expenditures are paid by the Federal Government; whereas, the remaining 20 percent either has to come from general funds or some type of what we call restricted funds.

And the way that CMS allows us to fund those is through multiple sources, including healthcare-related taxes. Sometimes you'll hear us refer to them as provider taxes, provider fees, provider assessments. These sort of taxes, they're imposed on healthcare providers as -- two different ways.

There's a percentage of revenue such as -- and I've given you an example of, like, five percent of revenues. Or we just do a flat tax, which is like a dollar amount per facility bed or per inpatient stay. Either one of those two, there is a maximum, a federal rule of six percent, that we cannot exceed. So at six percent of your revenues,

we're not allowed to go above that.

But the state Medicaid programs -- not just us. All state Medicaid programs across the nation utilize healthcare-related taxes to help accomplish various things. The most common is to support Medicaid payment rates. Another way is -- a lot of you hear of the HRIP program, or you hear of -- that we have the Hospital Rate Improvement Program now. Or we have an ambulance kind of directed payment as well.

To fund those, we do have -- the provider tax is how we use that in order to -- in order to fund those supplemental and directed payments. So some states use those.

Other states -- luckily, we haven't had to do this yet, but some states will try to avert a cut to Medicaid benefits. If the legislature starts cutting budgets and they have to look to cut -- and when I say "cut budgets," I mean cut the general fund that they provide the departments.

Sometimes states will say, hey, we're going to have to cut these benefits in order to meet the budget, but providers will agree

to pay the tax so that we can keep those benefits going. Another thing is to expand Medicaid benefits. Those are the most reasons that states use that.

But here in Kentucky, the majority -- the main thing, the most common thing that we use it for is the payment rates or the directed or supplemental payments.

The next three slides, I'm not going to go over too much in depth. My understanding is -- I've sent this presentation to Erin, and Erin is going to share that with you guys. So you'll have that with the meeting notes.

But the next one -- next several slides, I'm going to just go over a couple of federal requirements. Under -- I think last time that we met, I put in the chat the 42 CFR. That shows the 19 classes of services that we are allowed to utilize a healthcare provider tax.

So those are listed here. A few of them, I'll just mention. Inpatient and outpatient hospitals. We're allowed to do physician services, home healthcare services,

outpatient, drugs, ICF, IDD as long as it's -- there's a certain specification there that you can read -- read on.

But the next two slides just keeps going on those different types of services and different service classes that we're allowed to apply those healthcare-related taxes to.

So if you all have any questions on that after you see this, don't hesitate to email me or let me know. And I'll try to answer any questions you have on that -- those three slides. But it's just plain and simple. It's pretty short and cut to the point.

And all I did was try to break that out because I know how hard it is to read a federal register sometimes. I just wanted to put those into bullet points so that you all can see those services over those three slides.

This next slide, it's another federal requirement that we're allowed to do, but we have to meet three requirements. There's three requirements in order to do a healthcare-related.

It has to be broad based. Basically, it

can't just be on Medicaid. It has to be on all providers regardless if you take Medicaid or not. It has to be -- or if you have a higher type of -- you know, higher utilization or higher portion of your clientele is Medicaid, we can't -- we can't pretty much impose a different amount on you.

And that's where the uniformed imposed comes in. So rates cannot be higher on providers' Medicaid revenue than it is on a non-Medicaid revenue.

So you have to be broad based. You have to be uniformed imposed and then you can't -- you can't hold taxpayers harmless. And what that means is we can't guarantee that you'll be repaid for all or a portion of the amount of your taxes that they contribute.

Now, if you take Medicaid most times, you do. You may not get as much. But I am going to show you an example. And for simplicity, we've just made a few assumptions here. And what I'm about to go over is how we would update our Medicaid fee schedules with a provider tax.

Now, going into -- you know, I know that

90 percent of our care is now in managed care. You know, they have their own rates, but we would -- there is a process that we would have to follow to make sure that that goes through, and that's in the form of either a directed payment or vice versa of a -- you know, setting a limit or a floor or -- type of thing.

But what -- for the purpose of this illustration, this is just giving you a brief, very simplistic view of how this works. So in order for that, I'm going to show you a --

CHAIR PARTIN: Steve, we lost your audio.

MR. BECHTEL: Can you hear me now?

CHAIR PARTIN: Yes.

MR. BECHTEL: Okay. Let me get this little button out of my way, then. The -- I don't know what you heard. Where did -- so let me just start over.

So we're going to have the state -- in this illustration, the state has three providers and then -- that the state's current FMAP is 75 percent. So each one of

those three providers earns $1,000 in net patient revenue prior to the tax. And then I gave you a listing here.

Let's say provider one has a high Medicaid volume. Let's say 80 percent of that is Medicaid revenues, which accounts for 800 of the $1,000. Provider two is 20 percent volume which accounts for $200. And then provider three does not accept Medicaid and has $0 in Medicaid revenues; right?

So all three providers have to be assessed a uniformed and broad-based tax. And we're going to -- in this example, we're going to use a 2 percent of its net revenues. So 2 percent, each one of them will be paying $20, which for a total statewide assessment of $60 for those three providers.

The state can then -- when we collect that $60, we then take that $60 of state tax revenue, and we use that as our state share, our nonfederal amount. So we can use that as our state dollars, and we then turn that around and draw in the federal share. So 75 -- so, basically, you would be able to draw in an extra $180 on that $60 to then

turn around and pay out $240 back in the rates; okay?

So let me just show you -- this is a little bit better, I think, easier to follow for me. But it'll show you the three different providers, provider A, B, and C. You have the high volume, low volume, and no volume. Each of them are getting $1,000 a month in revenue, which is $3,000 statewide, $1,000 statewide of Medicaid volume. But you can see there, each provider has to pay $20, the 2 percent. Each provider has to do that.

And then what we could do is the increased rate, it would be sent in back into the way that you pay your -- you know, it'll be in your Medicaid revenue. So where the state down at the bottom gets $3,000 in total revenues, the 2 percent of tax, that's $60. And I've highlighted there that's the $60 that the providers will pay.

$60 represents the 25 percent of state funds. $180 is the 75 percent of federal; whereas, you'll get an additional funding of 240. So your previous Medicaid funding was $1,000 statewide; right? You're adding that

back in. That's 1,240. So that's a 24 percent rate increase. So you go back up, and you then apply that 24 percent to the -- to the Medicaid revenue because it has to be paid out in Medicaid revenue.

So you can see that provider A paid a -- you know, paid $20 but got a bigger return on their money than provider B. Provider C paid $20 and received nothing because they have to pay the tax. But if they're not receiving Medicaid or if they do not accept Medicaid members, they will not receive that.

And that's where we run into a lot of times where -- and I'm not just going to -- you know, we looked at doing -- I made a suggestion, I think, to Dr. Bobrowski on a phone call one time. We was looking at increasing dental rates at one time. And we said, hey, we can do a provider tax, but only 30 percent, I think, or 40 percent of the dentists in Kentucky accept Medicaid. So you would be applying a tax to a larger portion of providers that do not accept Medicaid, and so we felt that that wasn't the way to go.

So that's kind of a thing that you have

to look at when you look at these taxes. But I did provide you the formulas over here in the red on how these lines were calculated so that you all can kind of back into my numbers. But that was just an illustration of a permissible arrangement that CMS will allow us to have, and it's very simplistic.

It's very -- you know, when we're dealing with it in reality, it's not as simple as this. There is a lot more. It can get in the weeds. I don't want to get in the weeds on this call, but there are a lot of things that we have to do.

We have to do a test to make sure we're not exceeding that 6 percent that I told you about. We have to do other things. We have to submit some documents to CMS and show them that these are applied broad based and things like that.

So -- but if we did do one of these, again, this is just fee for service. This is just the fee-for-service rates that would be adjusted. So this example only assumes that all three of these are all -- are fee for service only.

So if we did do a managed care in order to increase that, that's where the directed payments that you hear about come into play where -- because we cannot tell the MCOs what rates to pay. But we can do a directed payment program which has tied to it quality measures and things like that to where we can say, hey, pay X number of dollars or pay a specific floor or -- on the rate fee schedule and that type of thing.

The last slide that I have here is just the federal and state regulations legislation so -- where you can go in. I wanted to provide that for you all, the different CFRs and what they are addressing as well as the state legislation. We -- for every provider tax we have, it's in the KRS. It's in the statutes, and I've provided you those chapter numbers. It's 142.301 through 142.363. So each one of those has their own class.

So is there any -- I know I went through that really quickly and very, very abruptly. I'm not a teacher by any means, but I'll do the best I can to address any questions or concerns you may have.

CHAIR PARTIN: Steve, this is Beth Partin. I have a couple of questions. For rural health clinics and FQHCs, would the tax be based on the fee that was paid minus the wrap payment, or would the wrap payment be included in that amount on the --

MR. BECHTEL: Well, I'm glad you brought that up. Rural health clinics and FQHCs are paid a PPS rate. We have to pay that federal PPS rate. There's nothing we can do there. I mean, we can -- we have to pay the -- it would not be in the wrap payment, I wouldn't believe, but --

CHAIR PARTIN: It would just be based on the fee that was paid by Medicaid and not --

MR. BECHTEL: It would be -- it would be -- I may have to defer to Veronica on that topic, but I believe FQHCs and RHCs are a little bit of a different animal where they have to be paid the PPS rate. So I'm not sure that we -- I don't -- go ahead, Veronica.

MS. JUDY-CECIL: Hi. This is Veronica Judy-Cecil, senior deputy

commissioner at Medicaid. I do not believe -- we could take that back, for that question. But I do not believe that they would be eligible for the provider tax model because, as Steve mentioned, they are paid the PPS rate. But we can take that back specifically.

CHAIR PARTIN: Okay. And then the other question is: How is the tax paid? Is it deducted from your fees, or is it a bill that you get?

MR. BECHTEL: No. There's all -- all the taxes are collected by the Department of Revenue, Kentucky Department of Revenue, and they do those collections. There's a form -- excuse me. There's a form that you have to submit with your payment.

Give me a minute. Let me -- I had a tickle.

But there's a form out there I can provide you. I can send that information to Erin, and she can provide that to you. There's a link out there for the Department of Revenue where it shows how they collect it. I believe that it's paid monthly, and

it's based on your revenues each month.

CHAIR PARTIN: Okay. So it would be a bill that the practice would receive?

MR. BECHTEL: Correct. Correct. But that would -- I would caveat that with -- that I'm not familiar with their processes, Department of Revenue's processes in collecting those funds. So there is a number there on that website for you to contact if you had any questions on it. But I will provide you the link to the Department of Revenue website so that you can see those.

CHAIR PARTIN: Okay. Thank you.

MS. BICKERS: Beth, Dr. Gupta had her hand raised, then Dr. Bobrowski, and then Dr. Compton. There's lots of questions.

MR. BECHTEL: Oh, good.

CHAIR PARTIN: Okay. Go ahead, first one. Dr. Gupta?

DR. GUPTA: Hi. This is Ashima Gupta. Yes. Thank you, Steve. That was really a great summary, and I feel like I understand it much better. I just wanted to confirm. So if this were to be applied, it couldn't just be, like, say, to, like, you

know, pediatricians. It would have to be to all healthcare providers in any facet across the board; right?

MR. BECHTEL: Correct.

DR. GUPTA: Okay. So it would really only benefit people who -- or providers who do see a lot of Medicaid patients. Because even in your example B, for those who accept 20 percent of Medicaid, they would still kind of be losing out a little bit; right?

MR. BECHTEL: That is correct. When we look at it, we look at it -- and you've heard the commissioner say a one-to-four match. You know, for every dollar you send in, you sometimes will get four dollars back. We're looking at that statewide, not just -- but you could see it really depends on your Medicaid volume on if you'll get that one-to-four match versus, you know, a lower match.

DR. GUPTA: Okay. Okay. Thank you.

MR. BECHTEL: All right. And when I said -- Dr. Gupta, when I said one to four,

what I mean is $60, $240. So for every dollar you send in, you're getting $4 back on a statewide look. But, obviously, like you said, provider B and provider C is not getting that type of return on their payments.

DR. GUPTA: Okay.

MR. BECHTEL: Yep.

CHAIR PARTIN: Okay. Was it Dr. Bobrowski was next?

DR. BOBROWSKI: Yes. Thank you. Steve, correct me if I'm wrong, but this is -- that form that you would fill out for the Department of Revenue, I believe it would be very similar to the use tax form that we pay now. You know, like, if we buy supplies from an out-of-state -- or buy gloves from an out-of-state vendor, we have to -- and they don't charge us a state sales tax, we have to fill that form out and pay the tax at that point. So I'm assuming it would be similar to that use tax form.

And then -- but the Kentucky Dental Association has talked about this numerous times, about the provider tax. And we've

talked with Steve about it somewhat, too. But just a lot of the dentists are not in favor of that because there's so many more that are not providers that would have to pay a tax, you know, to -- that they never have been a Medicaid provider. So that was one stumbling point for us, you know, getting this through the dental community.

The other thing was that a lot of the Medicaid providers felt that -- and please don't shoot the messenger. I'm just kind of telling you feelings out there, that it just felt like the Medicaid members were getting a lot more than even the provider dentists were getting.

And -- for an example, the MCOs would pay a gift card of about $50 to go and have a dental examination done, and the dentist would get $26. That was an example that was used.

The -- one of our reports that we received was, you know, that one of the MCOs, they even spend out over ten million dollars in value-added benefits to the members, which -- and I -- please don't shoot the

messenger but just the -- a lot of those items are necessary for folks but, you know, that was a major expense.

The dentists haven't had a fee increase in any Medicaid provider payments for 20 years up until we -- and I want to thank Commissioner Lee for working with us. But we are starting to get some. We've built up some of the oral surgery codes and fees, so I want to thank her and her staff for working with us on that.

And then the State -- I guess this is what we don't understand, is sometimes we see the State give tax incentives to other businesses to come into the state or tax incentives to a business that's expanding employment, you know, in their communities.

But yet when the MCOs came in, after about a year, several of the MCOs cut the rates to the provider dentists ten percent. So they already have experienced a 10 percent decrease and then now we're going to be asked again for a 5 or 6 percent tax.

So that -- I'm just kind of trying to explain the mindset and the thinking. And if

it's okay with you, I know the KDA has another executive board meeting coming up in a week or two. And I could share this information that you've sent out here today, Steve, if that's permissible and if I can get on the agenda to present that this quick. I may have to do it at their next meeting. But I just wanted to share some thoughts and sentiments on the dental arena with this, but I'll be quiet now. Thank you.

MR. BECHTEL: Okay. Yeah. I don't have a problem with you sharing this. It's going to be public anyways, public information. So I do not have an issue with you providing that.

DR. BOBROWSKI: Okay. Thank you.

MR. BECHTEL: I just ask that if there's any questions, please don't make assumptions. Always feel welcome to reach out, you know.

DR. BOBROWSKI: Yes. Okay. Yes.

MR. BECHTEL: As far as the incentives and bringing -- that's something that Medicaid is not involved with, so I can't address that, Dr. Bobrowski. But the

one comment, you know, that you made is -- where they are paying the member -- and I understand what you're saying. I do. And I'm not shooting the messenger there.

But whatever we need to do to get these -- our members in your all's doors to get that dental care, that's -- you know, if they're getting that dental care, that's what's most important to us, is that they're getting the care and that you all are getting payment. Now, we're working on the payment side of that.

DR. BOBROWSKI: Yes.

MR. BECHTEL: But that is -- that's the most important.

DR. BOBROWSKI: Well, I agree. And I know, working with Commissioner Lee and you all, too, that -- and you all -- other providers know that prevention is key to holding down the overall cost on multiple health avenues. So I think that's great to continue that.

And one of the other things is we've -- Commissioner Lee brought up that Kentucky is 49th in the nation in oral health care, and

we're looking at ideas on: How can we move Kentucky up that ladder? And I know we can't go from 49th to 1st overnight, but I think we've got to work as a community.

And I know, even around here, we've had several of our physicians and nurses, you know, talking with their patients. Say, look, you need to get into the dentist, you know. So that's -- we've got to encourage each other and our patients to follow up on care that might be out of our purview, but it's just all about -- it's all about patient care.

CHAIR PARTIN: Dr. Compton, I believe you were next.

DR. COMPTON: Yes. Steve, if I understood you right, you mentioned that the MCOs would be able to use a value-based system to determine payments to providers? Did I hear that right?

MR. BECHTEL: You mean through the -- from the provider tax itself?

DR. COMPTON: Well, yes.

MR. BECHTEL: We would have to fund that -- that funding would help us pay the

cap payments but then we would turn around, and we would do a -- what we consider a directed payment where a program, much like what we do for the Hospital Rate Improvement Program and the ambulance, where we say, hey, for every trip or for every inpatient discharge or things, you pay X number of dollars. And that funds that, that program.

So in your case, let's say that we had visits -- like, how many Medicaid people came in for an eye exam or something like that. We would pay, like, a per visit type of thing. So how many visits you had, we would set that up to where each provider got paid based on their Medicaid volume, their Medicaid visits.

But that would be something we'd have to get approved through CMS, and you'd have to tie what they call quality measures to it which says, hey, by doing this program, we're improving the health care of our state type of thing.

DR. COMPTON: Okay. So those value-based payments are not occurring now with the MCOs --

MR. BECHTEL: No.

DR. COMPTON: -- and any other provider groups? Okay.

MR. BECHTEL: No. Not in response to a provider tax, no, sir.

DR. COMPTON: Okay. But are they occurring at all now?

MR. BECHTEL: Value-based payments? Yeah. My understanding, there are value-based payments occurring in the managed care arena but not -- not for this subject here of provider taxes so...

DR. COMPTON: All right. Thank you.

CHAIR PARTIN: And, Peggy Roark, you had your hand raised.

MS. ROARK: Yes. This is Peggy Roark, a Medicaid recipient. I just wanted to add that as far as I know, this year and maybe last year, I haven't seen any gift cards for patients to go to the dentist, and the gift cards they give out is only $25. I've never seen a 50-dollar gift card, not unless all the MCOs are different.

CHAIR PARTIN: Okay. I guess that

would have to -- that would come under the information that we get when it's updated about what the MCOs are providing, incentives to the participants. And doesn't that usually come out at signup time; is that correct?

MS. ROARK: Well, you know, Janu- -- this was a new year, and I've went to some doctors. And I noticed that they wasn't giving no incentives for dental, and we need people to go to the dentist. Your teeth is important. And I go -- I go to the dentist. I don't need a gift card because I want to take care of my teeth but, you know, just to get people to go, like they do us in your well checks, eyeglass exams, and all that.

CHAIR PARTIN: Well, we will be talking about the update on the dental and hearing in a minute, so we can talk about that a little bit more later.

MS. ROARK: Okay. Thank you.

CHAIR PARTIN: Okay. Any other questions for Steve?

(No response.)

MR. BECHTEL: Okay. So I will -- like I said, I'll share -- I've already shared this presentation with Erin to send out to this group with the meeting minutes. But I'll also send -- Erin, I'll send you that link to the Department of Revenue, so they can see how the funds and the forms in which they have to fill out or -- on the Department of Revenue's website so...

MS. BICKERS: Thank you.

MR. BECHTEL: All right.

MR. MARTIN: Hey, Beth, this is Barry. I'm trying to see where I can raise my hand, but I don't see that option on my screen right here.

Steve, what programs would this impact?

MR. BECHTEL: It really depends on which -- it would be those services that -- those first three pages under the federal requirements that I was sharing with you, that it showed the different, like, inpatient hospital services, or we can do it on outpatient hospital services or nursing facilities or physician services. It's a wide variety --

MR. MARTIN: Okay.

MR. BECHTEL: -- of things.

MR. MARTIN: What about rural health clinics and FQs?

MR. BECHTEL: Right. That's what I -- what me and Veronica was talking about earlier. We don't know if that would apply to them because they're paid the PPS rate, so we would have to see how that would work.

MR. MARTIN: Okay. I'm sorry. I missed that part.

MR. BECHTEL: That's okay.

MR. MARTIN: I stepped away for a second.

CHAIR PARTIN: Okay. Thank you, Steve. Very informative.

If council members don't mind, we will be a little bit flexible here and allow Eric to talk about the PDS legislative rate increase before we move on to the other old business because he's going to have to leave.

DR. WRIGHT: Thank you, Chairman -- Chairwoman Partin. This is Eric Wright, and I represent Medicaid recipients and as a parent of two daughters with special needs on

the Michelle P. Waiver. I also am involved with social media channels related to Michelle P. Waiver recipients.

And there was a letter dated May 5th from the Department of Medicaid. I put that in the chat for everyone to be able to see. It relates to some questions that were requested March 24th from, it looks like, the district -- developmental districts and maybe DIAL. It says that ADD is currently receiving a 50 percent rate increase on half the rate of PDS coordination services.

And there's some questions about rate increases that I am still trying to understand, and I wanted to see if the Department can help those recipients, particularly those who utilize PDS services, to understand what the rate increase -- I mean, I guess I just am looking for more clarity.

And the letter -- I can share my screen if you want, but the letter has been included in the chat for everyone to take a look at. And so what I would like to do is just open up a conversation and a dialogue about this

rate increase letter that was sent out.

COMMISSIONER LEE: So this -- hi. This is Lisa. I think there are a couple of rate increases that we're discussing. As you know, one rate increase was associated with the budget bill that had a 10 percent -- I think a 10 percent legislative directed rate increase in there. And the other was related to temporary increases as a result of COVID -- of the COVID Public Health Emergency.

And I believe we have Alisha Clark on the phone -- on the call, too. Alisha works with the division of long-term care services, and that oversees the 1915C waivers including the PDS. So I think if Alisha is on, she may be able to answer a few more questions that you may have, Dr. Wright.

DR. WRIGHT: Yeah. I think the biggest question seems to be that this legislative rate increase was supposed to go in effect July 1, 2022, but it appears that that rate increase was not enacted at that point. There's been a lot of concern related to that amongst parents of providers -- of

recipients, too. I'm just curious about, if you had the legislative rate increase, why that would not be retroactive.

MS. CLARK: So -- yeah. Thank you. Good morning. So the legislative increase, that is -- it was done as of 7/1. However, you have to look at -- that our traditional agencies have all the overhead, all the additional stuff that they have to pay for. Whereas, when it comes to PDS, the employee is actually -- or not the employee, I'm sorry. The participant is actually hiring the employee.

So at that time, we have to do -- there's lots of stuff that has to be done on the back end. They have to get new contracts, all of that. And it's not that -- this isn't a requirement for people to just pay somebody an additional amount; right? It should be based on, you know, if they are -- they have certain skills that are needed. Maybe if you want to increase the pay, if you can't find an employee so to, you know, onboard an employee.

It's not just an automatic 10 percent

increase for the PDS population. There should be a lot of considerations taken on the back end on if they are going to increase a -- or an employee's pay. So that's something that has to be discussed with, you know, the participant, their -- possibly their rep, and the case manager. And new contracts would be needed for that.

DR. WRIGHT: And I understand those things. My question is, I know that this was -- you know, again, I'm thinking of this as somebody who is a member of this council and represents families, you know, that are recipients on PDS waiver services such as Michelle P. Waiver, SCL waiver, home and community-based services waiver.

And during these times when it was very difficult to recruit, particularly with the inflationary measures that we're -- you know, we're seeing across the state, why we are just being notified about these because I was not aware of any of these, you know, increases.

And so I think my concern is now: When will contracts be adjusted? Are we looking

at July 1, 2023, that the contracts will be adjusted, or is the department working with agencies to ensure that we know that we have the ability to increase this? Is this going to be a permanent increase? Is it temporary?

Why are PDS services -- the way I see it is, like, we're not being treated equitable in comparison to traditional services. And so I do have some concerns, and I'm just voicing it based upon thousands of people that I'm hearing on social media.

MS. CLARK: So just to -- you know, to kind of -- you know, traditional and PDS is a little bit different when you look at it because as a traditional agency, they have to hire. They have all the overhead. Whereas, you know, a participant doesn't have that. It's just, you know, they're hiring employees straight out. There's not all the other that they have to do.

DR. WRIGHT: And I -- I do get that. And, I guess, was the legislative intent to -- was to treat these two agencies in inequitable ways, or was the legislative intent to get a 10 percent increase across

all the services?

MS. CLARK: So let me also go back and tell you part of why this has been a little delayed or difficult to get in. Because with COVID, we had ARPA money that we were -- could spend. So you had to submit a plan to CMS, and CMS had to approve that. We had a lot of stuff in that plan and were working on moving forward when this legislative budget was approved. I know that there were advocates involved in that.

So what happened is then it told us in the budget that we had to use the ARPA funds in order to increase. So at some point, this money is going to run out using those ARPA funds. So when it said that, we had to redo our entire ARPA plan and send that to CMS.

So as soon as we got approval under that and was able to -- also, we had to modify our Appendix K. We then definitely started working to be able to put that in -- to do that as fast as possible for everybody.

DR. WRIGHT: So I guess my question -- go ahead. My question goes back to: Are we looking at this -- obviously, the

letter seems to very much clarify that we cannot do any retroactive increases even though the intent was the 1st for PDS services. When can families expect to say, hey, we can increase pay by 10 percent to be able to attract and retain employees?

MS. CLARK: You can't go back and create a -- you know, a contract that is -- that's already occurred. You know, the contracts have to go forward.

DR. WRIGHT: Okay. So when do we anticipate the agencies notifying participants that there is a 10 percent increase that they can be able to utilize to attract and retain employees?

MS. CLARK: We are working with them now and have had -- and started having those conversations. But I think that we need to definitely take into consideration that we do have a whole lot of PDS people within the state, and it's also going to take time for them. And, you know, this -- it shouldn't be an automatic 10 percent increase for everybody across the board. I think that the participant themselves or if they have a

guardian, they really need to take into consideration on, you know, the skills that the employees have.

DR. WRIGHT: Right.

MS. CLARK: You know, maybe how --

DR. WRIGHT: Who gets to make the determination?

MS. CLARK: It should be done through a person-centered service planning meetings.

DR. WRIGHT: And when do the agencies anticipate that they're going to get a notice to the parents about this?

MS. CLARK: That information, I will have to go back, and I don't have that in front of me. So I'll have to take that back.

COMMISSIONER LEE: Dr. Wright --

DR. WRIGHT: Yeah. Go ahead. And can we keep this on the agenda for our next meeting as well? I think we still have a lot of unanswered questions.

COMMISSIONER LEE: Dr. Wright, I was going -- I was going to ask if you think that it would be beneficial for maybe you and

a few others to just have a smaller meeting outside of the MAC meeting to discuss this topic in detail?

DR. WRIGHT: I think so. I think definitely.

COMMISSIONER LEE: Okay. So we can do that. We'll get another -- a smaller meeting on the books to answer and address some of your questions. You can definitely leave it on the agenda for the next time, too, in case we can't get to all your questions. But we'll schedule a meeting with you, and if you think there are others that need to be involved in that meeting, just let us know. And we'll schedule a meeting to discuss.

DR. WRIGHT: Well, I think it would be consumer affairs. You know, we do have those consumers that are now -- I think it's advocating for consumers to ensure that equitable services, equitable pay in both traditional and PDS needs to definitely be -- I mean, I'm advocating that it should be equitable. If there are traditional providers that are able to bill at a higher

rate, then we definitely need to keep it equitable so that we are able to attract and retain, particularly during this time when inflation wage increase has gone up significantly across the board over a two-year period.

COMMISSIONER LEE: Okay. So we'll get another -- I will reach out to you, Dr. Wright, after this meeting, and we'll get some names. I see, Steve, you've put something in the email, too. So we'll try to get a meeting together just for this very specific topic. Again --

DR. WRIGHT: I do appreciate that. I apologize that I won't be able to be on for about the next hour as I've got an appointment set up. But I appreciate you guys taking and looking at this, and I think it is definitely something that needs to be addressed by our MAC. Thank you.

COMMISSIONER LEE: Yes. Thank you.

CHAIR PARTIN: And, Eric, I'll keep it on the agenda. But if you get a resolution before the next meeting, just let me know, so I can take it off the agenda.

DR. WRIGHT: Thank you, Chairwoman Partin.

CHAIR PARTIN: Okay. Moving along, DMS report on billing for community health workers.

COMMISSIONER LEE: So community health workers, we have -- do have our State Plan Amendment approved. Services providers can begin billing July the 1st of 2023. We are working through our system changes and are getting some question and answer together.

We appreciate the dental community reaching out to us because the codes that we have are currently not on the dental fee schedule. They're CPT codes, not dental codes. So we're working through that to make sure that the dentists should be able to bill for those services as well.

We're also working through questions related to providers such as rural health clinics or FQHCs that may already be using community health workers and are receiving grant funds to pay for those community health workers. So we're having lots of internal

conversations and provider input as well as advocacy input as we work forward to plan for July 1st of 2023.

CHAIR PARTIN: Commissioner, who are the people that are considered community health workers?

COMMISSIONER LEE: They have to be -- a community health worker would have to be trained and certified through the Department For Public Health. I do have a very small PowerPoint presentation I can do at the next MAC, if you want me to, regarding the community health workers. But all community health workers would have to be certified.

CHAIR PARTIN: Yes. That would be helpful because I'm not familiar with them.

COMMISSIONER LEE: Okay.

CHAIR PARTIN: Okay. And then next up is --

MS. BICKERS: Beth, Peggy has her hand raised, but I'm not sure if it's a new question or she just never took it down.

CHAIR PARTIN: Okay. Peggy?

(No response.)

CHAIR PARTIN: Okay. I'm going to assume that she just didn't take it down. But, Peggy, if you have a question, just go ahead and speak up.

Okay. Next up --

DR. SCHUSTER: Beth, this is Sheila Schuster. And I never have figured out how to raise my hand, so I'm raising my hand. I guess I have a question for the commissioner because -- I'll ask this for my daughter who works at the FQHC in Louisville, and I know that she has grant funding for at least some of her CHWs.

So, Commissioner, are you getting input from some of the FQHCs that are in that situation?

COMMISSIONER LEE: Yes. We have received some comments from the FQHCs on whether they could -- for example, one question was: Can we bill for a community health worker if we're not using grant funds for that community health worker? You know, we just have to make sure that we're not duplicating paying for duplicate services, so there would have to be some sort of mechanism

for them to say, well, we hired this community health worker, and we're only going to bill for her. And we're using grant funds for other community health workers. So we have to -- and we also have input from the Department For Public Health related to who is receiving grant funds for those community health workers.

DR. SCHUSTER: Okay. I'm going to pass this information along to my daughter, if you don't mind. And I guess she can ask at the family health center if somebody is in touch with you because I'm pretty sure they have some grant funding for their CHWs there. Thank you.

MR. MARTIN: And if we have core grant funding, we have to be careful as well; right, Commissioner Lee?

COMMISSIONER LEE: Exactly.

MR. MARTIN: And rural health clinics will be able to bill as well for CHWs?

COMMISSIONER LEE: They will be able to bill. They are not subject to the wrap payments.

MR. MARTIN: Okay.

COMMISSIONER LEE: And, also, the MCOs will be covering, you know, community health workers. The MCOs are also -- I'm not sure if all of you are aware that the MCOs have been utilizing community health workers for quite some time for a variety of different reasons. All of the MCOs use community health workers. They will continue to utilize their community health workers for very specific outreach and things like that and then the providers will be able to bill.

We have -- in the presentation that we present at the next MAC, we'll outline who exactly can bill, what the codes are, what the rates are, and certification requirements for the -- for the community health workers.

MR. MARTIN: Beth and Sheila, the CHWs are kind of like the old health navigators; right, Commissioner?

COMMISSIONER LEE: Very similar, yes.

MR. MARTIN: Very similar. And that's been around for quite a while.

DR. SCHUSTER: Yeah. I'm familiar

and worked with Representative Moser actually on the legislation, 525, a year ago. I just had not thought about the grant-funded versus Medicaid-funded. I was trying to get some clarity on that so appreciate the information. Thank you.

CHAIR PARTIN: Okay. I'll put it on the next agenda, so we can get a little more -- a better understanding of that.

Okay. Next up is enhanced benefits update on dental and hearing. And in conjunction with that, Kent Gilbert wanted to have a discussion about the regulations on hearing, dental, and vision. And I sent out a link to those regulations to the MAC earlier and then they're cited on the agenda here. So I guess, is that you, Commissioner, or --

COMMISSIONER LEE: Sure. Sure. I can -- yes. So very excited about some of the numbers that we're receiving from the Managed Care Organizations in our system regarding some of the use of the new services. For example, 42,831 -- again, 42,831 adults now have got eyeglasses that

they did not have before. We think that is just phenomenal.

We also have -- as far as dental codes go, we have -- I was looking at some of our -- some of our dental codes. We have 1,115 individuals who have complete dentures. We also have another 1,100 that have other dentures and other codes related to dentures.

We have -- we're seeing a lot -- again, eyeglasses and vision is one of the highest codes that we're seeing come into play here. We are seeing quite a few dental services for adults. We are not seeing a lot of the -- a lot of the implants. We're seeing more crowns, root canals.

In all total, we have -- about 137,000 patients received these new enhanced services, 156,000 services in total. 22,394 billing providers have been using these services, and providers have received 7.5 million dollars on -- related to the new services. And that is from January through April of 2023.

CHAIR PARTIN: Wow.

COMMISSIONER LEE: Very excited.

You know, again, the number of glasses is just staggering, I think, to me in the short time frame, but 42,831 adults now with glasses.

CHAIR PARTIN: So the MCOs are now covering dentures?

COMMISSIONER LEE: Yes. Dentures and root canals and crowns, yes, for adults.

CHAIR PARTIN: Okay. Kent, do you have anything else you want to add to that or any questions you wanted to ask related to that?

MR. GILBERT: Yeah. Thank you so much and thank you, Commissioner. We're so grateful. I, as you know, represent the Kentucky Council of Churches. And, in part, a lot of our constituents are the folks who have gotten these glasses, and I wanted to celebrate with you how important this has been.

I also want to report to the MAC in general that, you know, I -- these regulations are so critical, and they're so important. But I also think they're kind of under threat. I'm not sure there's a full

and complete understanding at the legislature about just how -- what a good value these are. So I asked Dr. Partin if we could have that conversation and also then ask you about how we as a MAC can be supportive of keeping these. Because I know these regulations, once again, in a -- you know, a sort of an offseason hearing have been found quote, unquote, deficient.

But I want to lend whatever influence, whatever support we can from the folks who have gotten these dentures, from the folks who have finally gotten a root canal that's fixed pain they've had for years. You know, I just want to say this is a huge value, and the cost is incredibly small to the commonwealth.

I think the -- I don't know if you'd agree. But it just seems to me that the preventive nature of these things, and that is to say, people who can see can actually fill out job applications. People who don't have dental pain can actually -- and are seeing a dentist can actually get -- you know, prevent -- we can prevent problems that

would cause thousands and thousands of problems later.

So I'm just curious: What can we do to continue to support this as the process moves forward? And maybe perhaps you could give your perspective on where you think the process is right now.

COMMISSIONER LEE: So as you said, the regulations were found deficient at the last hearing. I think that was on May 9th. That was the emergency regulations. The ordinary regulations, I believe, are coming up on June the 13th. There may be a hearing. And I guess anyone who is supportive of these regulations is welcome to go to that hearing and voice their support.

We believe that, as you said, Kent, the preventative nature of this is just phenomenal. And we definitely want to give individuals their smiles back. We have heard so many good stories. We have been working with the dental technical advisory committee, and Dr. Bobrowski and his team have been very great about helping us look at some gaps or some inconsistencies on our fee schedule and

work those out. We believe that this is the very first step in revising the dental benefit package to actually start focusing on prevention. We know that dental care, oral health care is health care. We know that poor oral health care can lead to heart disease, diabetes, and even pre-term deliveries.

So there's a lot of focus, I think, on the dental component of this. But in addition, like you said, individuals with glasses can now complete a job application. They can drive. They can see. They're not going to stumble. They're not going to fall.

Individuals with hearing aids -- so we haven't seen -- we've just seen very few hearing aids. But individuals who are suffering in the first stages of hearing loss, as soon as they get those hearing aids, their risk of developing early onset dementia is reduced in that very first year by over 18 percent.

So, again, we believe these are very vital services. We think they are preventive in nature. And as Dr. Bobrowski said, we are

ranked 49th in the nation in oral health care. Now, in 2014, we were ranked 47th in overall health care in the state. We expanded Medicaid. We've been doing things differently. We've been working with the MACs and the TACs on our healthcare policies.

And now in 2022, we were 43rd. So it does show that we can increase in the ranks. And so now that we're 49th in the nation in oral health care, we believe that these services are vital to helping us move up the ranks in oral health care.

And there are several states, including Virginia, who has expanded their oral health care to adults and in much greater capacity than we have. For example, Virginia now covers three dental cleanings for adults; whereas, our services have two dental cleanings for adults per year.

So, again, I think just supporting these regulations and helping us show the value that we're bringing to the Medicaid population. The communications that we've been having -- I think that's one criticism that we have had is that it doesn't appear

that we communicated some of our intent for the regulations and for these new services, but we have been communicating that since August of 2022.

So I think going to the hearing, the regulation hearing and supporting these services would help us in making sure that they continue, and that future legislation doesn't block us from continuing to deliver these vitally important services to our members.

MR. GILBERT: I want to underscore that, and I particularly want to underscore that for those providers who are on the call right now. You know, if -- I want to speak gently but frankly about the state of the legislature, which is not generally predisposed to any kind of social service expansion. And I think they have misappropriated some rhetoric that does not -- I think is not helpful in terms of both supporting Kentuckians nor economically.

Providers on this call as well as others, if we don't speak up -- if they can't hear from the MCOs, if we don't hear from

those doctors and dentists and vision and hearing audiologists, if the legislature doesn't hear from you in the comments, I'm very afraid that these are just going to be axed as another expansion that we don't need and we don't want.

And that would be tragic for all of our constituencies including providers. 7.5 million dollars in just the first five months paid out to providers. I really think that this has many secondary economic benefits as well as simply the well-being of our most vulnerable Kentuckians.

So I see that Emily Beauregard has put a comment collector and also that the comment period ends on 5/31. I have taken initiative -- I filled out that comment collector.

I would like to ask that the MAC members please, please make their own comments on that collector or another kind. You can send a letter. Written comments are being received. There is, I think, as the commissioner mentioned, a meeting in July for the next set of these regs, and they're all

referenced in our mailings.

I -- like I say, I was not at all happy with what I was hearing in that legislative hearing. I felt like there was grave misunderstanding, and there simply was not a presence from the powers that speak most loudly at the legislature, and that's frankly the providers. That's you all.

You know, I stand up as a pastor of a church, as a leader of a number of denominations. And I say, we think this is important for poor people. And they're like, uh-huh, that's nice. At the moment, the voices that will speak loudest, I think, are those of you who are in the field, those of you who are giving the services, those of you who are managing this care.

And I am very, very interested to make sure that we have enough providers who are offering these services because of how valuable members and friends in my network have talked about what they have been able to do with them. So I think as the word continues to get out, I want to see that there is support across the board from all of

us on this call, whether you're a member of the MAC or whether you are one of the constituent agencies.

If we don't put comments in there, they are going to listen to their own rhetoric, which is it's money. We don't have money. Let's not do this when, in fact, this is money that we're investing, and we are saving. And I just hope that we will take my invitation and do what you can with it.

CHAIR PARTIN: Thank you.

MS. BICKERS: Beth, we have a couple of hands raised, and I will grab what Emily dropped in the chat and send that along with the email as well. I believe it went Dr. Gupta, Dr. Hanna, Dr. Bobrowski.

CHAIR PARTIN: Go ahead, Dr. Gupta.

DR. GUPTA: Okay. Thank you. Pastor Gilbert, thank you so much for bringing all that to our attention, and I'll definitely make a comment and try to pass that message along.

Commissioner Lee, what is the actual benefit for glasses? Is it one pair of glasses a year per adult, and does that

include contact lenses?

COMMISSIONER LEE: The actual benefit is one pair of glasses -- we may even have a dollar amount. I'll have to pull up the regulation and look, and it does include contact lenses.

DR. GUPTA: Is that per year or every two years?

COMMISSIONER LEE: I may have to have someone in policy help me. Is it every year or every 36 months? I can pull up the regulation and drop that in the chat.

DR. GUPTA: Okay.

MS. BICKERS: I think I saw Kelly Kitchen on. I'm not sure if she can answer that.

MS. KITCHEN: This is Kelly Kitchen.

COMMISSIONER LEE: Kelly, do you know what the benefit is for glasses in the regulation?

MS. KITCHEN: Yes.

COMMISSIONER LEE: Is it a dollar amount -- it's a dollar amount, or is it frames? It's per year.

MS. KITCHEN: It's per year, and there is a dollar amount. We are increasing that to the advanced frames.

DR. GUPTA: And they could get glasses and contacts together in one year or alternate?

MS. KITCHEN: No. They can get glasses. And if it's medically necessary, they can receive contacts.

DR. GUPTA: Okay.

COMMISSIONER LEE: And we had input from the optometric TAC related to the contact lenses. And so it is -- if there is some reason that they -- that an individual cannot wear glasses, then medical necessity would allow them to get contact lenses.

And, again, I'd like to thank the optometric TAC for everything that they -- all of the input that they've had on those new regulations. And, again, the comment period -- we have the emergency regulations in place now. That comment period will allow us to get comments and make amendments to the ordinary regulation as we go forward.

DR. GUPTA: Okay. That's great.

Finally. I'm so happy that we're putting more efforts into prevention. That's a long-term solution. Our children will appreciate that for us.

COMMISSIONER LEE: We're very excited about the opportunities these will bring. And, again, I think going back to the dental, we know that we spend over nine million dollars a year in emergency room visits for -- related to dental issues, and we're hoping that that money is going to be -- you know, going to be reduced. And that'll be more money that we can put into the dental community into -- a lot of work still to go, a lot of work. But this is definitely a first step.

DR. GUPTA: Thank you.

CHAIR PARTIN: Who was next on hand raised?

COMMISSIONER LEE: I think it was Dr. Bobrowski, maybe.

DR. BOBROWSKI: Okay. Pastor Kent, I just -- you had asked about how to support the dental, hearing, and vision and Medicaid in general. But you hit it, the nail right

on the head. We as providers or just members of the state of Kentucky, we have to educate our own legislators. You know, your legislators may not know me. They know you. So I think it's so important to talk with your personal legislators.

And right now, this summer and early fall is such a great time. Because once session starts in January, our -- those legislators are extremely busy. So right now, this summer and this fall is a good time to just go talk to your legislators.

And, again, I always want to thank Commissioner Lee for -- we've been talking about this in our TAC for years, about building smiles, getting people work ready so that they can go to work and not have to put their hand over their mouth.

So these are wonderful things to -- like I said, we've got some issues to work through. Any change you make, you've always got to fine-tune it. That's just part of the nature of making changes.

But those are things that I just wanted to kind of re-emphasize what Kent was talking

about, was just the -- it's our job to educate our legislators in the value of getting folks work ready, build their smiles to even just increase and better their self-esteem but -- thank you.

CHAIR PARTIN: And who else was next? There was somebody else?

COMMISSIONER LEE: Dr. Hanna?

DR. HANNA: There we go. I just had a question. Was the 7.5 million, was that through state funds exclusively?

COMMISSIONER LEE: No. That was federal and state funds combined. That's the amount of the claim so -- claim payments. I know there's been a few numbers floating around. We finally -- we've been working on these reports for a while, and we finally finalized and made sure that that was strictly for the adult population. So that is all funds total.

DR. HANNA: Thank you.

CHAIR PARTIN: Commissioner, if we wanted to comment on the regs and speak to the objections, was this the ARRS committee, and what were their objections?

COMMISSIONER LEE: So, Jonathan, I may need a little help with that question.

MR. SCOTT: Hello. Jonathan Scott, DMS reg coordinator. The objections were, I think -- they've primarily been about cost. We've -- I can also forward you the governor's letter where he put the emergency regulations back into effect. That's a public document that's gone out in the last few days.

But there were a lot of just general concerns about the Medicaid program that were mentioned. They were wanting to talk about different ways that we could spend the funds and just talk about authorization, whether they've given authorization, whether we already had authorization existing in our system.

So a lot of the comments that we've gotten have focused on the value of the services, the public safety benefits, the return on investment, the medical values that we're seeing. So we've gotten a lot of great comments.

We had a public hearing last week.

Reverend Gilbert attended as well as KVH and the KOHC. So we've gotten a lot of really good comments so would love to hear anything else you have to say. The emergency regulation comment period is open through the end of this month. The ordinary regulation comment period will remain open through next month.

So you can send the comments that you have to the comment aggregator that was mentioned, but you can also email them to chfsregs@ky.gov. You can also send them to me, and we'll include them in the eventual statement of consideration that will be issued. There's also the possibility that we'll make some amended after comments versions of the reg as well as we go through and keep getting information.

CHAIR PARTIN: Okay. And it's the ARRS committee?

MR. SCOTT: Yes. ARRS.

CHAIR PARTIN: Okay. Thank you. Any other comments?

DR. SCHUSTER: Beth, this is Sheila Schuster, and I just wanted to say -- and, of

course, I think behavioral health is about everything, so this is about behavioral health, too. If people are in chronic pain, as we know they are, with -- particularly with dental pain, their mental health is not good. And, actually, Dr. Bobrowski talked like a good psychologist, talking about self-esteem and the ability to smile and not have to be embarrassed about your looks, about your teeth, about bad breath, about those kinds of things.

But the other thing that is really a puzzle to me -- and I read the comments from the legislators at the ARRS meeting. You know, the legislature has been so critical of people who are Medicaid members, saying that they are not participating in the workforce and using really pejorative descriptions of people.

And it is so frustrating to me that if you think about hearing, vision, and dental, what -- what could be more productive for people to get them work ready than those things? I mean, Kent said it well. You can't pull out a job application. You can't

do your work if you can't see.

We know that undetected and untreated hearing loss -- and the commissioner pointed out the correlation with early onset dementia. But that is such an isolating disability to have, to have hearing loss that's untreated and makes it almost impossible for people to enter into the workforce. And then we've already talked about the dental benefits.

So I think there's a lot to be said for those of us who serve on the MAC as representatives of Medicaid members. There's so much here that's ripe for comment. So I so appreciate Kent bringing this to the MAC and to KVH for collecting those comments. Thank you.

CHAIR PARTIN: And I would like to add to that. Nutrition. You know, if you don't -- if you don't have teeth and you have diabetes, you can't eat the food that you need to eat. You're eating noodles and things that aren't helpful for people who are diabetic because they can't chew fruits and vegetables and other healthy foods.

So besides the problems with poor dentition leading to endocarditis and all other kinds of physical problems, nutrition, I think, is at the top of my list as far as people who don't have teeth. So, you know, lots of reasons why this is important.

Any other questions? Okay. Commissioner, you're up again.

COMMISSIONER LEE: So I have a couple of updates, I think, some good news. We just recently received a State Plan Amendment approval for -- to add licensed alcohol and drug counselors and behavioral health associates to our array of billing providers. I think that'll probably be something that will most likely be discussed in the next Behavioral Health TAC meeting.

As you know, there have been federal rules that came out that mandated states cover -- provide continuous coverage for children effective January 1st of 2024. And as part of our unwinding efforts, we decided to go ahead and implement that April 1st of 2023. So we are now currently having -- we have 12 months' continuous coverage for

children.

We just wrapped up some provider forums. I saw many of you out there. We had a really good turnout. For those of you who could not participate in the forums, we are providing -- pulling together some question and answers, and they will be provided on our website. They will be posted along with all of the presentations that were delivered during the public -- during the provider forums.

And, you know, the presentations mainly were focused on just some of the updates that we have done during the Public Health Emergency such as community health workers. You'll see a lot of information on community health workers. We also had some focus on behavioral health, our Kynect state-based exchange, and unwinding efforts.

So I think with that, I think the deputy -- senior deputy commissioner, Veronica Judy-Cecil is on here, and she can give you an update on unwinding.

MS. JUDY-CECIL: Hello again. Nice to see everybody. I am going to share my

screen, and I will do my best to not take too long. But I get talking about unwinding and restarting renewals, and I lose track of time.

So I did try to focus only on an update from the last presentation that we provided to the MAC at the last meeting. Can you all see my screen? Is that showing?

CHAIR PARTIN: Yes.

MS. JUDY-CECIL: Thank you. So one thing I want to note that has changed since the last time -- and part of this is due to the fact that we are implementing 12 months' continuous coverage for children. In order to ensure that children that are going through a renewal during this 12-month unwinding period have access to that benefit, we have pushed a majority of those cases to start in September so that our system will be ready to do that in an automatic way.

Until then, we are doing a manual process for any child determined eligible because there are some children still going through a renewal. But if they are determined eligible, we will retroactively

add that 12 months' continuous coverage to them to make sure they don't get disenrolled due to a change in circumstance.

So we have pushed those cases, majority of them, to start in September, which is a change in our caseload distribution. So I wanted to -- I don't think we've shared this information in this format, but this is -- this is what our distribution looks like over the 12 months.

Of course, we've already -- you know, May 31st is quickly approaching. We are concerned about that, and I'll talk about that in a minute. June renewals, notices have already gone out. Those went out towards the beginning of May, so we're now working on both May and June renewals.

But just to show you, by pushing those cases with children in them, it has greatly increased -- not greatly but has increased our caseloads towards the end of the unwinding period. We will continue to monitor that in terms of workload.

Our department for community-based services, who makes eligibility

determinations and redeterminations, has been part of this conversation, making sure that they have the ability to handle that higher caseload towards the end of the unwinding.

But, you know, just to point out -- again, I've spoken to this -- is we are trying to keep November and December as some of our lowest caseloads due to the holidays and shorter workdays.

This was the -- since we last met, we did file our unwinding baseline data report with CMS. This is a requirement for the 8th of every month that we'll provide an update about what happened in the previous month. So this was just level setting with CMS, a snapshot of what our system looked like as we start to unwind.

Not a lot of information in here that is particularly helpful. But just to let you know, that's been filed. It is on our website, as is the May 8th report that we filed that told CMS basically how many cases have we started -- have we initiated for renewal, how many fair hearings have been requested. So that report is on our

unwinding website, and we'll continue to post those.

Just wanted to provide some updated information on what we're seeing for both May and June renewals. So in May, we had a little over 72,000 cases, and we do process at the case level. I've mentioned that before.

So there could be several folks in the household that are part of that case. Some households have one person. Some have two. Some have three. But we do do it at the case level.

Of those, 49,500 were determined passive. If you recall, what that means is they are cases that we can go out and ping the federal hub which has a bunch of different databases: IRS, citizenship, immigration. We can go out and verify information through that process, and there's nothing that the member generally has to do.

So we had 49,500 passive cases and 22,930 active cases. And the active cases are the ones that get that renewal packet because there's a lot more information that

we need and to verify to be able to determine their eligibility.

So just as a snapshot, since May 15th for May, we have completed 3,200 actual renewals. So folks have responded to those notices, sent those in. Almost 2,300 of those determined eligible.

239 are transitioning to QHP. What that means is that our system -- even though they're no longer eligible for Medicaid, we can tell that they are eligible based on income for a Qualified Health Plan and the advanced premium tax credits that make those plans affordable. So we call it transitioning but, basically, what's happening is those individuals are being sent to the marketplace. They're notified that they need to choose a plan, and they should do that before the end of their coverage so that there's no gap. So 239 of those in May.

And then 913 have been determined ineligible, so their termination will happen on May 31st because we've already made that determination. We had information and were able to make that.

Just to note, of the passive cases, in May, we were able to successfully passively renew 60 percent of those. So that means that of those passive cases, 60 percent, we went out and verified their information on that federal hub. They don't have to do anything further. Their coverage is already automatically extended for 12 months.

Anybody that we couldn't passively renew but -- what we do is send them a request for information. So you're going to hear passive with RFI a lot when we talk about the population. So they do have to still respond prior to their end date to let us know if there's -- to verify something because we weren't able to complete that by doing that automatic verification.

So in June, similar. We have about 73,000 cases. Active case -- passive cases were a little higher this month, and let me stop and say you cannot look at one month and extrapolate that across the 12 months. Every month is different.

I showed you that redistribution of the caseload. That's because we have prioritized

populations in different months. So you can't take one month and say, oh, well, this is what's going to happen next month. It's very different. And that's challenging, I know, for folks. Because you want to take data, and you want to use it, and you want to forecast. But it really is impossible to do that by looking at a month.

So for June -- because you can see, there's quite a -- there is quite a difference already. We had a higher number of passive cases. So we had a higher number of cases that would qualify for us to go out and automatically renew, but we had -- only 50 percent of those cases we were able to automatically renew.

These are lower than what is typical prior to the Public Health Emergency but not unexpected since we're unwinding. And the reason is because we do know we have a lot of folks that are covered, because we kept them covered during the three years, that are covered that are ineligible. We know it.

But what we want to make sure is that we are getting that right, we're making the

determination correctly, and that we're connecting them to other coverage. You've heard me talk about that a lot. That's the other critical piece. Are they Medicaid eligible? Then let's make sure they complete everything they need to remain Medicaid coverable. But if not, let's make sure they are covered in some other way, so Medicare, employer-sponsored, a Qualified Health Plan.

So also to note, in June, we had about 17,000 active cases. Active cases are primarily or majority fee for service. So they're the ones that are in our nursing facilities, in our 1915C waivers. So when you see active case, the majority of those are fee for service.

For June, we've already processed 444 cases. And as you can see, 363 have been already determined eligible, 33 have transitioned over to the marketplace, and 81 have unfortunately been determined ineligible.

Lots and lots of outreach we're continuing. So we are calling every single active renewal. If the member has a renewal

packet or gets a request for information at the beginning of their renewal time, we are calling that household. And we are going to keep calling them until we reach them, until we -- they understand that they have to take action.

So we are doing that through our contact center. The Managed Care Organizations are also outreaching to these folks because, really, the critical piece here is that they take action prior to the end of their coverage, either -- whatever they need to do to stay in Medicaid or to move over to another healthcare coverage.

So we did do a combined 40,000 renewal notices. There are almost 45,000, those passive renewals requests for information that I told you about. So we dropped those individuals -- when we couldn't verify them, we've dropped them to that RFI.

That will mean we are going to have probably a higher number of individuals that are administratively terminated. But keep in mind, that doesn't mean that they're eligible and they didn't take action. It just means

we sent them a notice. But maybe they know they're no longer eligible, so they're not responding. But they're going to be categorized as administratively terminated because we did send them a notice. So we're really trying to make sure everyone understands that number is going to look high, but we are making sure that individuals who are still Medicaid eligible are able to take action and complete that.

We've sent over 57,000 email messages as a result of somebody's renewal. We are getting -- we are seeing some undeliverable mail. And as soon as it comes back to us, we are immediately outreaching to the person in whatever mode of communication we have available to them. If there is an updated change of address that's reported back to us, we will resend the notice to them.

We also have implemented the national change of address database. So now, prior to sending out notices, we will go out and ping that database. And if somebody has taken that step to report their change of address, our system will automatically consume that

new address and send the notice to that address. We just redid that and went back and captured some folks in June that we're now going ahead and resending some of those notices back to.

But at the bottom of the slide, you'll see that -- lots of contacts. So the alert calls are those ones we're making to say, hey, you've got an active renewal. Make sure you're paying attention to that. The nudges are where we've received something, but it's not enough.

And we want to make sure they know that additional action is needed on their part, so we're calling them back and saying please make sure that you're sending this additional information in because we can't complete your redetermination. If that doesn't happen, by the end of the month -- so, you know, for May, May 31st, then, you know, they will be disenrolled.

And the good news that we keep trying to remind everyone is that a member has 90 days after their termination to still complete that renewal. And if they do and they're

eligible, we will reinstate them back to their end date so that there is no gap. So even if you're seeing, as a provider, a member come in and they've just lost coverage, it's still good to remind them, hey, why don't you contact the state. Why don't you see if you can get that taken care of because if you do, your coverage will be reinstated.

This looks tiny, but what this is just letting you know is that May 8th report that we sent to CMS on our unwinding website, again, just letting CMS know how many -- how many beneficiaries were eligible for renewal, how many hearings have been filed, and it's just our way to track the metrics.

The other thing that has changed since we last talked that I want to make sure all providers understand, and that is the Office of Civil Rights, which is the office that ensures compliance with HIPAA-compliant platforms for telehealth -- so we are not changing telehealth, what services can be delivered by telehealth. But the Office of Civil Rights has clarified that beginning

August 9th, they're going to start enforcing the use of HIPAA-compliant platforms.

So if you're using FaceTime, FaceTime is probably not HIPAA-compliant. Just make sure -- if you're a provider that has used some of the probably easier platforms out there, just make sure that it's compliant and that you're using a compliant one starting August 9th. We did want to make sure that providers were aware of that.

We also -- I think -- I don't think I had this information when we last met, but we did add to KYHealth-Net the redetermination date of a member. So all providers can go into KYHealth-Net and see on the member panel that member's redetermination date.

A couple of things to note. Some members don't have one, and the reason for that is not everybody has an annual renewal that's required. So it may not reflect that there's an actual redetermination date.

What happens is when that person's circumstances change so they're no longer eligible for whatever category granted them Medicaid eligibility, then that's when they

would get redetermined. And they may lose eligibility unless they qualify for another category.

The other thing is there might be an old date on there. And if there is, that is just our system kind of being -- you know, being the system it is. And it just -- it just captured an old date. That date is likely the date they came into Medicaid, but they are not subject to an annual renewal.

Now, just because they're not subject to an annual renewal doesn't mean that if they -- if they're -- during the three years, if they lost eligibility for some reason, we will be processing them, and they will get a notice. But most -- most individuals will have a date.

So as a patient comes in, a couple of things we're asking. Please check their -- because you're checking their eligibility anyway; right? So maybe check to see when the renewal date is. If it's close, if it's in the next 30 to 60 days, share that information with the member. Make sure they're watching for notices. Give them the

Kynect hotline to call to check. Just -- just, again, to make sure that they know that something is happening.

We know that you all as providers ask for updated contact information. So you, when the patient comes in, generally ask: Has anything changed? Your address? Your phone number? Well, if you see somebody's information has changed, a Medicaid member information has changed, that's the other opportunity that we're asking providers to say to the member: Have you updated that with Medicaid?

It's important that we have the updated contact information because, as I mentioned, lots of outreach is going on. We want to make sure they receive their notice. We want to make sure we can call them and help them understand what's happening.

If you are a waiver provider or a long-term carry and you use the Kentucky level of care system, KLOCS, there is a report that you can pull out of that that tells you when your patient's renewal date is. So that's another feature that we've

added to that system.

There's also -- so there's a quick reference guide available. There's also some specific FAQs related to the waiver providers because they have a different authority under which we've been operating for their flexibility. So it's called Appendix K.

Appendix K doesn't expire until six months after the Public Health Emergency. So all those flexibilities are generally tied until November 3rd -- excuse me, November 11th. But we are communicating with those providers, and we will keep you updated on, as that approaches, what's happening.

I just want to stress one other thing that we're really focusing on, is that a member who is no longer Medicaid eligible and does move over and wants to choose a plan on -- a Qualified Health Plan on the exchange, they have to choose the plan prior to the end date, or there will be a gap in coverage.

Because for the exchange, those -- that coverage is always prospective. There is no retroactivity with the qualified health plan.

So if a member, for example, with a May 31st end date does not go over and choose that health plan before the end of this month, they will have a gap in coverage. So we're just trying to reenforce that.

The other thing I want to note is that just because a parent, guardian, or head of household is no longer eligible does not mean that child is not eligible. If there's a child in the household, the child may still qualify because we have different federal poverty levels for children. So we also want to make sure that individuals understand that if the parent has to go out and choose a qualified health plan, that doesn't mean the child has to, you know, too. That child could still remain in Medicaid.

So we're trying to make sure that everyone understands. That's why it's really important to look at the notice and respond to it because we put that in the notice, to make sure they understand that you might go choose a Qualified Health Plan, but your child could remain covered by Medicaid if you respond to the notice.

Website, just to reenforce, lots of information on there. We're continually updating it. So a great way to pull down information to learn about what's happening.

And then ongoing stakeholder meetings. The third Thursday of every month during the unwinding period at 11:00 a.m. Eastern Time. If you cannot attend, we will record and post it including any question -- responses to any questions. So at your convenience, you can go out and see that.

And then I'm going to reiterate, we're really utilizing social media to keep everyone updated. It is the quickest and easiest way for us to provide information. We were made aware of a scam. And later that day, we were able to post it.

So if you just follow one, Facebook, Twitter, or Instagram, just like us or follow us on one of those just to keep updated on what's going on with all things unwinding.

All right. And I'm happy to take any questions.

CHAIR PARTIN: That was a lot.

MS. JUDY-CECIL: And we will send

these slides out to you as well.

CHAIR PARTIN: Okay. That would be great. Thank you.

MS. JUDY-CECIL: Reverend Gilbert --

MS. BICKERS: We have -- oh, sorry, Veronica.

MS. JUDY-CECIL: That's okay. Go ahead.

MR. GILBERT: Oh, okay. Veronica, thank you so much. Listen, I'm a little concerned about those numbers, about 17,000, 20,000 unprocessed. Is there a paperwork backlog? I mean, how are you handling that, and how does that affect renewals?

MS. JUDY-CECIL: Oh, excellent question because it's not that there's a backlog. What we're finding is really slow to respond. And I was on a national call with eligibility leaders on Tuesday, and this is not unusual. At least, it's not -- Kentucky is not the only state experiencing this. That doesn't make it okay.

I think what's strange for us is that we are doing so much outreach. So like I said,

calling households, texting, emailing. You know, we're doing so much outreach, yet we're still seeing the response rate to be a little slow. However, I do anticipate, and we -- I should say we anticipate that we know that there's a large percentage -- our normal average is 9.8 percent of terminations per month prior to the Public Health Emergency.

I think we're anticipating that to be a little closer to 15 percent, and the reason for that is because we know we have folks who are no longer eligible. And so they are probably not responding to the notices.

But, you know, that's not going to stop us from continuing to reach them prior to the end of the month. And then we will -- we do plan to go back -- after May 31st, we do plan to go back and evaluate who dropped off, and what do we know about them. Do we know that they're in Medicare? Do we know that they have third-party liability? So they've got an employer-sponsored plan. You know, did they go enroll in a QHP?

So we're going to go back and -- in those three months following, we will

continue to outreach to folks. And the Managed Care Organizations will, too, to reach people who have been terminated just to give them that 90 days' opportunity, that if something happened and, you know, maybe they thought they were no longer eligible, you know, give them that opportunity to come back in.

But, you know, we are monitoring the State's ability to process. It's not -- it's not at a critical mass yet. And I will say that any member whose determination has not been made -- so they've responded. We have something on file, but we haven't processed it. They do not get terminated. They do not get terminated until we make a determination.

So we do, though, expect -- you know, we're seeing the response rate now start to creep up. But, you know, we are concerned about the large numbers that haven't responded.

MR. GILBERT: A quick follow-up and then I'll turn it over to Sheila. If I'm on Medicaid, is there a portal where I can go in and see what you showed that the providers

can see? Can I see my termination date? Can I see my status? Can I see my claims?

MS. JUDY-CECIL: Absolutely, yes. A Medicaid member can get into Kynect, and we've been encouraging them to create that Kynect account.

MR. GILBERT: Yeah.

MS. JUDY-CECIL: Understanding that's not --

MR. GILBERT: I know. That's not everybody's thing.

MS. JUDY-CECIL: You know, it's not for everybody.

MR. GILBERT: Yeah.

MS. JUDY-CECIL: That's right. But yes, you can go onto Kynect and then you can -- in that account, you'll get notices as well. So in that -- and you can upload. You could take -- on your phone, you could take a picture of a document and upload it that way.

So it is a great -- it is a great resource for individuals who have the ability to go and create that account. The other thing they can do -- and some of the system improvements that we've made is that they can

call in, and they can, through that automated process, find out what their date is as well. So they can call the hotline. They can -- if all they're wanting to know is when their redetermination date is, they can also do it that way.

MR. GILBERT: Thank you.

DR. SCHUSTER: Veronica, this is Sheila Schuster, and thank you for this great information. And I applaud Medicaid for doing the active outreach that you all are doing. I'm amazed that the returned mail was, like, 2,500. I mean, I remember back in the day -- because you and I go back way back in Medicaid, that we used to -- it felt like tens of thousands of letters that were returned to Medicaid; is that right?

MS. JUDY-CECIL: We did have about a 30 to 40 percent return rate. That is correct.

DR. SCHUSTER: Yeah. That's amazing, and it really shows how the word has gotten out for people to at least update their addresses.

The other question I have is really

about the telehealth piece, which you've touched on, because this has come up in several ways at the last BH TAC meeting. And I think Medicaid has -- I mean, CMS has made some changes in the use of telehealth for Medicare patients. And that got a little confusing, I think, around hospital maybe outpatient behavioral health services.

But is CMS looking at maybe issuing new guidance on making more platforms HIPAA compliant?

MS. JUDY-CECIL: I -- so interestingly enough, I think the change is actually coming from the platform side. So I think the -- like, FaceTime, I think they're looking at their platforms to find out what can they do to make it more HIPAA-compliant.

You know, I honestly cannot guess what the Office of Civil Rights or CMS might do to try to make that a little less onerous and burdensome. But I do know -- I have heard that the platforms themselves are trying to make those changes.

DR. SCHUSTER: Yeah. I'm hoping they will because I think people have gotten

into the habit, both the providers and the members, of communicating on non-HIPAA-compliant platforms. And I think it's going to be a rude awakening when we get to that point, so I hope that's the case.

MS. JUDY-CECIL: Yeah. And that's one of the reasons we wanted to talk about it, is just to make sure everyone understands what's going on. But it's out of our control.

DR. SCHUSTER: Yeah. I know it's -- I know if you all were making the rules, we would have lots more platforms be deemed HIPAA-compliant. But you all will make sure that all of us represented here on the MAC and all the TACs get notified of any changes that are made with regard to platforms, telehealth platforms?

MS. JUDY-CECIL: Yes. Definitely.

DR. SCHUSTER: Yeah. Thank you so much, Veronica. Great information.

MS. JUDY-CECIL: You're welcome.

DR. SCHUSTER: And you're going to share this. Or Erin can send this out to us, and we'll have it.

MS. JUDY-CECIL: Yes.

DR. SCHUSTER: Wonderful. Thank you.

MS. JUDY-CECIL: She has it.

DR. SCHUSTER: Yeah. Thank you.

CHAIR PARTIN: Thank you. Any other questions?

MS. JUDY-CECIL: So it looks like there is just one other thing I want to mention. So MCOs are working really closely with providers. If a provider wants to be super involved and supportive, the -- I know the MCOs are providing, especially to primary care providers, their PCP lists of members and when their renewal date is so that if a member comes in regularly, you can already have that information available to you.

So if you want to be really proactive, certainly reach out to your Managed Care Organizations. They know, you know, to try to work and partner with providers through that.

But, you know, I think one of the challenges is that we have to be careful about how we're sharing information. So

we're just being really sensitive to the lists that we're providing through that -- through that mechanism. We want to make sure there is that provider/patient relationship.

So thank you. I'll stop there.

CHAIR PARTIN: Thank you. I'm going to put this back on the agenda for next meeting just so we can get updates; okay?

Okay. Anything else from you, Commissioner?

MS. JUDY-CECIL: I don't think she had anything else to share.

CHAIR PARTIN: Okay. Thank you. Okay. Then we will move along to the TAC reports. And we have about 30 minutes, so that's not a lot of time for all of these reports.

So I would ask that the TACs who are reporting, just give your recommendations. And I'm sorry we don't have time to get other good information. But next meeting, maybe if you have to leave stuff out, you can share it.

MR. MERRITT: Sure. Absolutely. Do you want me to go ahead, Elizabeth?

CHAIR PARTIN: Are you therapy?

MR. MERRITT: So no. My name is Patrick Merritt. I did send a message. I'm the new Primary Care TAC chairman.

CHAIR PARTIN: Okay.

MR. MERRITT: So I do have to step off at 11:00. I didn't know if you wanted me to give a report really quick on our findings or recommendations before I do step off.

CHAIR PARTIN: Okay. We'll go out of order. You're second today so go ahead and then we'll go back to therapy.

MR. MERRITT: Yeah. Really quick, and I won't take up much of your time. Thank you so much. Like I said, my name is Patrick Merritt. I am the new chair for the Primary Care TAC.

We did have the privilege to meet on May 4th. We were able to introduce all the new members of the TAC committee. We received updates from the Senior Deputy Commissioner Cecil as well as the MCOs. And at this time, there are no specific recommendations for the MAC.

CHAIR PARTIN: Okay. Thank you.

MR. MERRITT: Yes, ma'am.

CHAIR PARTIN: Therapy Services?

(No response.)

CHAIR PARTIN: Physician Services?

DR. GUPTA: This is Dr. Ashima Gupta. The Physician TAC met on May 19th. We had a quorum. We decided to table our two recommendations, so I have no recommendations to offer right now.

CHAIR PARTIN: Okay. Thank you.

Pharmacy?

DR. HANNA: The PTAC did not meet since our last meeting.

CHAIR PARTIN: Okay.

Persons Returning to Society From Incarceration?

MR. SHANNON: Steve Shannon. We had no recommendations. I put that in the comments. Thank you.

CHAIR PARTIN: Thank you.

Optometry?

DR. COMPTON: Yes. We met on May 4th. Had a very productive meeting, but we have no recommendations at this time.

CHAIR PARTIN: Thank you.

Whoa. We're going to -- we are going to move through this quickly.

Nursing Services?

MS. BICKERS: I don't think they have a rep on today, Beth.

CHAIR PARTIN: Okay. Thank you.

Nursing Home?

MR. JOHNSON: This is Wayne Johnson with the Kentucky Association For Healthcare Facilities. We do not have a TAC report.

CHAIR PARTIN: Thank you.

Intellectual and Developmental Disabilities?

MR. CHRISTMAN: Oh, I'm sorry. Yes. We met on April the 4th, and we have the following recommendation: That the Department of Medicaid Services in conjunction with the department for IDD and CAP review and revise as necessary the regulations regarding the involuntary termination of services for people who participate in the SCL and Michelle P. Waivers. That's it.

CHAIR PARTIN: Okay. Thank you.

Hospital?

MR. RANALLO: This is Russ Ranallo for the Hospital TAC. The Hospital TAC did not meet. Our next meeting is in June.

CHAIR PARTIN: Thank you.

Home Health?

MS. BICKERS: They have not had a meeting this year.

CHAIR PARTIN: Okay.

Health Disparities?

MR. BURKE: Yeah. This is Jordan Burke. I'm the chair for the Health Equity and Disparity TAC. We met on May 3rd. We don't have any recommendations at this time.

CHAIR PARTIN: Thank you.

EMS?

MR. SMITH: Yes. This is Keith Smith, the EMS TAC. The EMS TAC met on April 24th. However, we did not have quorum. We don't have any recommendations at this point, but I did want to brief the committee that the issues that we had before as far as EMS services closing down this summer is still ongoing.

We still appear to have distance between the insurance companies and what EMS needs to

move forward, and it's getting to the point now that EMS services are having to bill hospitals because they are unable to get payment for the services they are doing through Medicare. One hospital has contacted me that they've got a bill for over $50,000 from one insurance -- or from one EMS company. Another hospital has $7,000 worth of bills to cover or being asked to cover because they're not getting paid. And another hospital has had close to $10,000 worth of bills sent to them because of Medicaid not being able to get paid because of the preauthorization issues.

So we do have some significant issues within the EMS TAC that we're trying to work on. Other than that, we have no other business.

CHAIR PARTIN: Okay. Thank you. Please keep us updated on that.

MR. SMITH: Yes, ma'am.

CHAIR PARTIN: Dental?

DR. BOBROWSKI: Yes. This is Dr. Bobrowski. We're continuing to work with DMS. We're just out here killing germs and

building smiles. But we don't have any recommendations to the MAC. Thank you.

CHAIR PARTIN: Thank you.

Steve Shannon, did you have -- I see your comment. Is that something that you need to say to the MAC, or is that something to DMS?

MR. SHANNON: DMS primarily.

CHAIR PARTIN: Okay. Thank you.

Consumer Rights and Client Needs?

MS. BEAUREGARD: Good afternoon, everyone. Emily Beauregard with Kentucky Voices for Health and chair of the Consumer TAC. We met on April 20th. We did have a quorum, and we met remotely using Zoom. We revisited and discussed a number of the topics that we typically do.

Just real briefly, I do want to express our appreciation for all of the work that DMS is doing related to Medicaid renewals. We often -- well, I should say in my particular organization, we talk with a lot of national groups on a regular basis. And we know what, you know, is happening in other states.

We've seen some of this in the news, and

Kentucky really is being very, very proactive and putting in place, you know, as many sorts of flexibilities and as much, you know, information, education, opportunity to, you know, find those renewal dates and to be proactive as, you know, possible. And so we think that that's all been, you know, really beneficial for Kentuckians with Medicaid coverage.

I will second, you know, Kent's concerns about the low response rate, and I think that it is really up to all of us stakeholders, you know, whether we're advocates or providers, to be reaching out to Kentuckians of Medicaid coverage proactively, not waiting until they end up coming in for care and finding out that they've lost their coverage.

So anything that we can do to share information and to make sure that we are asking people if they've received anything in the mail or helping them find that renewal date, I think, would be really, really helpful at this point. And knowing that so many of those active cases are people in long-term care and people with waiver

programs, I think, providers play an even bigger role in that situation. So just something to really keep in mind and to work into, you know, what you're doing in your practice.

And also really appreciate the new updated dental, vision, and hearing regulations. We are collecting comments, as I mentioned in the chat, and have been pleased to already receive about 50. I'm hoping to continue to collect more, of course.

So not only would we love for members of the MACs and TACs to submit comments but also, of course, to share because most people aren't aware, you know, of public comment periods, especially when they're for things like a regulation. And so getting it out to people in a form that is a little easier for them to receive and to engage with, I think, can be helpful.

And as far as those regs go, you know, we know that these services are critical to people's health. We know that there's a fantastic return on investment. We have

heard, of course, that there's a network adequacy issue. And I think we need to continue to work on network adequacy, whether that's increasing rates to have more providers participating, but that's not really, I think, the primary way. Making sure that MCOs are providing adequate networks and that we, you know, have enough providers who are participating in the program, that's really where we're going to make the most impact because that's how people actually receive the services.

But we don't want that to overshadow the fact that these are absolutely necessary services, and I think that we need to just be clear in our comments, you know, not to -- not to let the rate conversation overshadow the rest of it. That's something that we need to continue working on long-term.

And I was happy to hear Steve's presentation earlier about those -- you know, how you could potentially leverage the provider TACs to increase rates. I think there's clearly some, you know, limitations there. I would love to hear more about that,

you know, value-based payment and the opportunities to do essentially what hospitals have done with tying quality metrics to increase payments and if we can do that for other provider types as well. So just something to think about.

We did make a few recommendations at our April meeting for the MAC's consideration. And the first is that DMS create an orientation packet for all new TAC and MAC members so that people can, you know, participate a little more effectively, be more engaged, understand terms and a little bit more of a history of these programs.

That's especially true for consumers, of course, or stakeholders who aren't Medicaid providers, but I even think Medicaid providers often kind of get thrown into something, the policy side of things that they don't necessarily -- aren't necessarily that familiar with.

Our second recommendation is that DMS track and report on the impact of House Bill 75 for hospital-based outpatient providers and independent providers. So

House Bill 75, of course, was creating that opportunity for hospitals to be paid the average commercial rate for meeting certain quality metrics, similar to what hospitals have been getting for inpatient. And we know the independent providers weren't included in that so want to see how we can potentially look at the impact and perhaps do the same thing outside of hospitals.

And the third recommendation is that DMS track and report on the impact that House Bill 525 has on access to CHW services, those community health workers that were discussed earlier.

So those were our recommendations. Our TAC will be meeting again on June 7th. Thanks.

CHAIR PARTIN: Thank you, Emily. Children's Health?

MS. WHATLEY: Hi. Alicia Whatley with Kentucky Youth Advocates and the Children's Health TAC. We did meet on Wednesday, May 10th, but we do not have any recommendations at this time.

CHAIR PARTIN: Thank you.

Behavioral Health?

DR. SCHUSTER: The Behavioral Health TAC met on May 11th. We had a quorum. We had people there from DMS and DBHDID.

We do have a recommendation to the MAC. The BH TAC recommends to the MAC that Kentucky Medicaid establish and distribute a clear policy statement on targeted case management as it relates to an integrated plan of care for the individual to whom TCM is being provided. This policy statement should be developed and distributed as quickly as possible because of recoupment actions being taken by a Medicaid MCO against providers of targeted case management.

This was a new issue. We have -- one of the MCOs has decided to take a very different interpretation of a regulation that has been in effect since 2015 on what constitutes targeted case management and has come back on several providers in big amounts of recoupment. And we think this is unconscionable, quite frankly.

And so we reached out in the meeting, and I'm happy to say that I've had some

preliminary feedback from Leslie Hoffman, that she and Stephanie Craycraft who is the acting commissioner of the Department For Behavioral Health, Developmental Intellectual Disabilities are working on this.

But it's a little bit scary, folks, when a service like targeted case management that is really the -- I think the life breath -- the life support for so many people with significant behavioral health issues and has been delivered by providers for years and years and years, is operating according to a reg that's been effect for eight years. And then one of the MCOs up and decides that they're going to interpret it differently and come back and try to recoup tens of thousands of dollars from a provider. So we are hoping for a quick resolution of that, and that's our recommendation.

I would like to thank Deputy Commissioner Hoffmann and other DMS staff who worked so diligently and came up with a way to find a workaround. You may remember at the last MAC meeting, that we sounded the alarm on a new change that had been made

where codes for extended therapy time limits had been just taken off the books. And we know that we have clients who need more than the traditional 50-minute hour of therapy. And it was remarkable how quickly the Deputy Commissioner Hoffmann and Commissioner Craycraft worked to resolve that issue and have issued the information to all the providers for a workaround. So we really thank them for that quick work.

We do have several issues that are of concern, and one of them -- well, another success, let me just say that, is -- and you've heard me talk about the problems that we have with dual eligibles, people that have Medicaid and Medicare or have Medicaid and a commercial insurer. And we have finally -- not we, but the MCOs have come together led by Herb Ellis from Humana and have signed off on -- and DMS has now signed off on a bypass list for clients that have both Medicaid and a commercial insurer.

So this solves a problem that I think Steve Shannon and I have been working on for at least 15 years. And we are just very

grateful for the work of the MCOs to come together and to work with DMS staff.

I must ask, though -- because we have now heard that Medicaid -- Medicaid is thinking about putting all dual eligibles into fee for service rather than MCO payment. And, Madam Chair, I don't know if it's possible for me to ask that question as part of my report. If not, I will need for you to put it on for the next meeting. But if somebody from Medicaid can respond to that, I would appreciate it.

MS. JUDY-CECIL: I don't think there's anything we can share at this time.

DR. SCHUSTER: Okay. Then I would request, Madam Chair, that we put that issue on, and I'll send you an email with the wording. But, basically, we've worked so hard now to be able to work with the MCOs and get payment for people that have dual eligibility; in other words, more than one payer, Medicaid plus another payer. And if DMS is looking at putting all of them now in fee for service, we would certainly like to know that.

The other thing that came up at the most recent ARRS meeting was a response, I believe, from Commissioner Lee about -- that Medicaid was doing a behavioral health rate study, which was the first that any of us had heard about that. And we will be asking about that at our next BH TAC meeting.

And if we -- you know, I don't see how DMS can do a BH rate study without including providers or without at least letting us know that it's ongoing. So we will have that on our next meeting, which will be on July 13th.

Thank you very much.

CHAIR PARTIN: Okay. Thank you. Do we have any other business?

(No response.)

CHAIR PARTIN: Okay. Would somebody like to make a motion to accept the reports and recommendations from the TACs?

MR. GILBERT: So moved.

CHAIR PARTIN: Second?

MS. ROARK: This is Peggy Roark.

DR. BOBROWSKI: Second.

CHAIR PARTIN: Any discussion?

(No response.)

CHAIR PARTIN: All in favor, say aye.

(Aye.)

CHAIR PARTIN: Any opposed?

(No response.)

CHAIR PARTIN: Okay. Reports and recommendations accepted.

Okay. Since we have no other business -- do we have any other business? Somebody want to say something?

DR. SCHUSTER: I think it was just throat clearing.

CHAIR PARTIN: Okay. Thank you. Okay. Would somebody --

MS. BASHAM: Hey, Beth, this is Nicole Basham with Passport. I just wanted to ask a question. I know there's an expectation the MCOs present in the summer months to the MAC.

Is there a required outline or deck that you would like to see, or are there talking points you'd like to see? Or is that not yet developed?

CHAIR PARTIN: It would be the same outline that we used last year.

MS. BASHAM: Okay. Okay. Thank you. I just wanted to get clarification.

CHAIR PARTIN: Okay. Anything else?

(No response.)

MR. OWEN: This is Stuart Owen with WellCare. So regarding that, last year, it was in July -- or excuse me, January that it was announced that MCOs would present, and there was a schedule. And they're very large presentations, so -- and I think they began in May, maybe even in March.

So I guess -- yeah. I mean -- yeah. I mean, we just need something official on that, something firm on that. Because it's already late May, and this is -- you know, would be the first that we're hearing about it. And it takes a while to, you know, prepare the data and everything.

CHAIR PARTIN: Sure. We'll get that out right away.

MR. OWEN: Okay. Thank you.

MS. BICKERS: Yeah. Beth, if you -- this is Erin with DMS. If you don't mind to send me that information. You hadn't

requested any presentations from the MCOs, so I hadn't put anything out to them. So if you can just let me know what you would like from them, I will get that information out to them, and we'll create a schedule on when they need to present over the next few meetings.

CHAIR PARTIN: Do we have -- do you have the outline from last year that we used?

MS. JUDY-CECIL: We do. Yes. We can revive that, and we'll send it over to you and just see if there's anything you want to adjust on it.

CHAIR PARTIN: Okay. Perfect. Thank you.

MS. JUDY-CECIL: Yep.

CHAIR PARTIN: Okay. So go ahead and get that to me and then, Erin, we'll go ahead and -- in the next week or so, we'll get the schedule out if that's okay with you.

MS. BICKERS: Yes, ma'am.

CHAIR PARTIN: Okay. Thank you. Anything else?

(No response.)

CHAIR PARTIN: Okay. Does somebody

want to make a motion to adjourn?

DR. SCHUSTER: So moved.

CHAIR PARTIN: Second?

DR. BOBROWSKI: Second.

CHAIR PARTIN: Who was second?

DR. BOBROWSKI: Bobrowski.

CHAIR PARTIN: Okay. Thank you. Okay. All in favor?

(Aye.)

CHAIR PARTIN: Thank you, everybody. We'll see you July.

(Meeting concluded at 12:22 p.m.)

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C E R T I F I C A T E

I, SHANA SPENCER, Certified Realtime Reporter and Registered Professional Reporter, do hereby certify that the foregoing typewritten pages are a true and accurate transcript of the proceedings to the best of my ability.

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

Dated this 6th day of June, 2023.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR