CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

July 22, 2021
10:30 A.M.
(All Participants Appeared via Zoom or Telephonically)

MEETING

APPEARANCES

Elizabeth Partin
CHAIR

Nina Eisner
Steven Compton
Jerry Roberts
Catherine Hanna
Ashima Gupta
Ann-Tyler Morgan
Garth Bobrowski
John Muller
Peggy Roark
Barry Martin
Eric Wright
John Dadds
COUNCIL MEMBERS PRESENT

CAPITAL CITY COURT REPORTING
TERRI H. PELOSI, COURT REPORTER
900 CHESTNUT DRIVE
FRANKFORT, KENTUCKY 40601
(502) 223-1118

AGENDA

1. Call to order 4

2. Roll Call 4

3. Approval of minutes from the May meeting .. 5

4. Election of Chair, Vice Chair and Secretary 5 - 7

5. Old Business
   A. Thank you, Commissioner, for agreeing to post recordings of TAC and MAC meetings on the DMS web site 7
   B. Follow-up on request from the Hospital TAC regarding some IMDs not being paid by some MCOs as per Managed Medicaid 42 CFR Part 438 .... 7 - 9
   C. Has any work been done to amend the Medicaid regulation to reimburse Certified Professional Midwives (CPMs)? .... 9 - 10
   D. Request amendment to the Rural Health Clinic regulation 907 KAR 1:082 Section (1)(b)2 on page 16 to extend the time to three days for providers to sign Medicaid participant’s chart. Three days would be in with her regulations and more realistic in busy clinic settings.................. 10 - 11
   E. Reminder that we will have an update report from DMS on maternal/infant health at the November MAC meeting........ 11

6. Judge Phillip Shepherd, Franklin Circuit Court, ruled in late April that the bidding process (the second one) for awarding the MCO contracts was flawed and must be rebid. What are the immediate and long- term effects of the Judge’s ruling that the MCO contracts must be re-bid? How does DMS plan to proceed? .... 11 - 12

7. Updates from Commissioner Lee .... 12 - 32

AGENDA
(Continued)

8. Reports and Recommendations from TACs
*Behavioral Health .... 32 - 36
*Children's Health .... (No report)
*Consumer Rights and Client Needs ...... 36 - 41
*Dental .... 41 - 43
*Nursing Home Care .... 43 - 45
*Home Health .... (No report)
*Hospital Care .... 46 - 48
*Intellectual and Developmental
Disabilities .... (No report)
*Nursing Services .... (No report)
*Optometric Care .... (No report)
*Pharmacy .... (No report)
*Physician Services .... 49 - 51
*Podiatric Care .... (No report)
*Primary Care 51
*Therapy Services .... (No report)

9. New Business .... 52 - 57

10. Adjourn 57

1 DR. PARTIN: We will call the
2 meeting to order. And for the roll call, Teresa, our
3 Secretary, was not able to join us today. So,
4 Sharley, you've got your hands full right now but I
5 don't have a list of members.
6 MS. HUGHES: I've got it right
7 here. I'll do it for you, Dr. Partin.
8 (ROLL CALL)
9 MS. HUGHES: I believe you have
10 enough for a quorum, and, Beth, there's two more new
11 members that are to be appointed as of July 1, but I
12 have not received word from the Governor's Office
13 that they have been appointed yet.
14 So, Barry is representing the
15 Kentucky Primary Care Association.
16 MR. MARTIN: Yes. I'm
17 representing the Primary Care TAC. Glad to be on
18 board.
19 MS. HUGHES: Thanks, Barry, and
20 I've got the agenda up now.
21 DR. PARTIN: Thanks, Sharley.
22 Next item on the agenda is the election of the Chair,
23 Vice-Chair and Secretary. Sharley, the only nominees
24 that I saw were myself for Chair and Dr. Bobrowski
25 for Vice-Chair and Teresa for Secretary. Do we have

1 any other nominees?
2 MS. HUGHES: Yes, but first you
3 skipped over the approval of the May minutes, unless
4 you did it and I didn't hear it.
5 DR. PARTIN: So, we have
6 approval of the minutes for the May meeting. Would
7 somebody like to make a motion to approve the
8 minutes?
9 DR. BOBROWSKI: This is Dr.
10 Bobrowski. So moved.
11 DR. HANNA: Second. Cathy.
12 DR. PARTIN: Any discussion?
13 All in favor say aye. Any opposed? So moved. Thank
14 you.
15 MS. HUGHES: We do have Nina
16 Eisner has expressed a desire to be for Chair.
17 DR. PARTIN: I'm sorry, Sharley.
18 You cut out. I couldn't hear what you said.
19 MS. HUGHES: I'm sorry. I'm
20 trying to do so many things at one time here.
21 Nina Eisner has expressed an
22 interest in being the Chair. So, I have created a
23 poll. Can you all see the poll showing?
24 (MAC members confirm)
25 So, only MAC members can vote.

1 So, if you all will please cast your votes, and this
2 is anonymous. So, even I can't see who.
3 (MAC members vote)
4 MS. HUGHES: It looks like, Dr.
5 Partin, you will be the Chair.
6 DR. PARTIN: Thank you,
7 everybody.
8 MS. HUGHES: So, you can go
9 ahead and continue. If you all want to see them, you
10 can see the results there now.
11 So, Beth, go forth. I'm going
12 to mute myself and take a couple of deep breaths now.
13 Have I lost Dr. Partin?
14 MS. CECIL: No, but, Sharley, if
15 you could go ahead and put the agenda back up,
16 please.
17 MS. HUGHES: Oh, I'm sorry.
18 DR. PARTIN: Do we have any - we
19 didn't have any other nominees for Vice-Chair or
20 Secretary?
21 MS. HUGHES: No, ma'am. That
22 was it.
23 DR. PARTIN: Okay. Thank you.
24 So, then, the Vice-Chair and the Secretary will
25 remain the same.

1 MS. HUGHES: Yes.

2 DR. PARTIN: Okay. Thank you.

3 Now to Old Business. I would like to thank the

4 Commissioner for agreeing to post recordings of TAC

5 and MAC meetings on the DMS website when those

6 meetings are recorded.

7 I had a number of requests for

8 this and I know people will be happy to have that

9 opportunity if they're not able to attend the meeting

10 to hear what went on.

11 We're going to follow up on the

12 request from the Hospital TAC regarding some IMD's

13 not being paid by some MCOs as per Managed Medicaid

14 42 CFR Part 438.

15 Nina, do you have anything you

16 would like to add to that or any questions?

17 MS. EISNER: Yes. Thank you. I

18 do. I did have a meeting with DMS leadership on 6/25

19 and appreciate that for the folks that are in

20 attendance but I still don't have any further update,

21 and I don't know if the Commissioner or anyone else

22 does.

23 DR. PARTIN: So, have you had a

24 resolution to this?

25 MS. EISNER: No.

1 DR. PARTIN: Do we need to keep
2 it on the agenda?
3 MS. EISNER: Yes, please.
4 MS. PARKER: This is Angie
5 Parker with Medicaid. As Nina had stated, we did
6 meet with her and Matt (inaudible) on June 25th, the
7 Commissioner and the Senior Deputy Commissioner, and
8 we did discuss the issue.
9 I know that at that point, the
10 Commissioner had talked to the one MCO in particular
11 and they were to follow up. So, my assumption is
12 that that has not occurred.
13 MS. EISNER: That's correct,
14 Angie.
15 MS. PARKER: Okay. I will
16 follow up with that. Anything else to add to that?
17 MS. EISNER: No. Thank you.
18 DR. PARTIN: Do we need to keep
19 this on the agenda for the next meeting or are you
20 going to follow up with outside meetings, Nina?
21 MS. EISNER: I'd rather leave it
22 on until it's resolved, please.
23 DR. PARTIN: I'm sorry. I
24 couldn't hear what you said.
25 MS. EISNER: I would rather

1 leave it on, please, until it's resolved.
2 DR. PARTIN: Okay.
3 MS. EISNER: Thank you.
4 DR. PARTIN: So, we'll put it on
5 for the next meeting.
6 Next up, has any work been done
7 to amend the Medicaid regulation to reimburse
8 Certified Professional Midwives?
9 MS. CECIL: Good morning, Dr.
10 Partin. This is Veronica Cecil with Kentucky
11 Medicaid. And first I want to say I apologize
12 because Commissioner Lee could not be with us today.
13 She certainly tries to always make it to the MAC but
14 she could not be here today. So, we're going to do
15 our best to fill her shoes by several of us.
16 With regard to this issue, what
17 our plan is, is this is part of an overall infant and
18 maternal health review that Dr. Theriot, as you know,
19 is moving forward with.
20 So, we have no plans until we
21 have a more comprehensive plan on what we're going to
22 do with maternal health to make any changes right
23 now.
24 So, you're welcome to keep this
25 on the agenda but our response is going to be that

1 when Dr. Theriot provides her update in November, at
2 that time, we will certainly share with the MAC what
3 our plans are.
4 DR. PARTIN: Okay. So, in
5 November, we'll know what's going to happen with the
6 CPMs as far as reimbursement?
7 MS. CECIL: That's correct,
8 because we, again, are incorporating that in a more
9 comprehensive maternal health initiative.
10 DR. PARTIN: Okay. I'll keep it
11 on the agenda just as a reminder to myself to ask
12 about that, but I understand that at our next
13 meeting, there will not be an answer but just to keep
14 it on the plate. Okay?
15 MS. CECIL: Okay. Sounds good.
16 Thank you.
17 DR. PARTIN: Thank you. Okay.
18 Next on the agenda is to request amendment to the
19 rural health clinic regulation 907 KAR 1:082, Section
20 1)(b)2, to extend the time to three days for
21 providers to sign Medicaid participant's chart. Three
22 days would be in line with the regulations and more
23 realistic in a busy clinic setting. Where are we
24 with that?
25 MS. CECIL: Sure. As

1 Commissioner Lee had mentioned previously, it is on
2 the list for us to amend. It's a very long list of
3 regulations that we've had to prioritize. So, we do
4 anticipate getting to that. Where it is on the list
5 is probably our goal is around September.
6 And Jonathan Scott will be
7 providing an update on regulations, the status of
8 regulations on the Commissioner's update.
9 DR. PARTIN: Okay. I will keep
10 that on the agenda as well and hopefully we'll have
11 an answer in September.
12 And the next item is just a
13 reminder that we'll have an update on maternal/infant
14 health at the November MAC meeting and I'll keep that
15 on the agenda as well just as a reminder.
16 And, then, finally, Judge
17 Phillip Shepherd of Franklin Court ruled in late
18 April that the bidding process which was the second
19 one for awarding the MCO contracts was flawed and
20 must be re-bid. What are the immediate and long-term
21 effects of the Judge's ruling that the MCO contracts
22 must be re-bid, and how does DMS plan to proceed?
23 MS. CECIL: So, appeals had to
24 be filed by Friday of last week and there were
25 appeals. So, we are now in that cycle of a continual

1 court case. And because there is an active lawsuit
2 on this, there's nothing more we can say right now
3 except that we're waiting for more court guidance----
4 DR. PARTIN: So, was it DMS who
5 appealed? I'm sorry. I didn't mean to interrupt
6 you.
7 MS. CECIL: No, that's okay.
8 So, the Finance Cabinet had not filed an original
9 appeal. There were multiple Managed Care
10 Organizations that filed an appeal, but the Cabinet
11 continues to evaluate its legal position.
12 DR. PARTIN: So, it's the MCOs
13 who filed the appeal?
14 MS. CECIL: They did file
15 initial appeals, yes.
16 DR. PARTIN: Okay. So, I will
17 keep that on the agenda also.
18 So, in the meantime, what are
19 we following as far as the contracts for the MCOs?
20 MS. CECIL: The current
21 contracts remain in effect.
22 DR. PARTIN: Okay. Thank you.
23 And next up is updates. I guess that's you,
24 Veronica, as well.
25 MS. CECIL: That is correct.

1 So, a couple of things that Commissioner Lee
2 definitely wanted us to update you all on.
3 The first thing is she always
4 likes to provide the enrollment numbers, and our
5 weekly report shows 1,565,664 members. That's a
6 snapshot, of course, but that's the snapshot for this
7 week, and 1.3 million of those are in Managed Care.
8 The next thing is our Senate
9 Bill 50 which is the single Managed Care Organization
10 Pharmacy Benefit Manager implementation that I'm
11 going to shorten to MCO PBM, and we did implement
12 that on July 1st. MedImpact is our single MCO PBM.
13 I think with any new
14 implementation, you're always going to have hiccups
15 and we tried to be very candid and transparent that
16 nothing is 100% perfect, but I have to say that from
17 an evaluation perspective, we find that it was very
18 successful.
19 We believe that MedImpact did
20 just a wonderful job of when issues were identified,
21 addressing them immediately, outreaching to
22 pharmacies, helping to make sure that members are
23 getting the medications that they need.
24 So, in terms of major systemic
25 issues, we really didn't see any. That's not to say

1 that it was, again, perfect, but there are things
2 that we're dealing with on kind of a one-to-one
3 basis.
4 I think it worked the way they
5 anticipated. There's a lot of transparency with it.
6 We aligned the reimbursement to fee-for-service and
7 the dispense fee to fee-for-service. I think that
8 helped.
9 I think for the most part, the
10 single PDL helped. There's still, I think, some
11 education going on around what does that mean when a
12 drug is on the PDL and what has to happen and that
13 transition for members, but, again, having one PBM
14 handling that as opposed to six I think has made it
15 easier on the member, on the pharmacy and that
16 certainly was one of the goals. So, I wanted to
17 provide that update.
18 The other thing is the
19 Commissioner wanted me to provide some updated data
20 on the missed and cancelled appointments' initiative.
21 So, since March, we have 6,522
22 reports by providers, and that's a unique provider
23 count of 209. So, we had 209 unique providers
24 uploading information into KYHealthNet about missed
25 and cancelled appointments.

1 The difficulty is that we have
2 some general buckets that a provider can choose.
3 And, so, our top two buckets are Unknown and Other;
4 but behind that, for cancelled appointments, the next
5 reason was for just an unforeseen issue; and for
6 missed appointments, it was forgot about appointment.
7 So, again, I think this is
8 helpful for the Department and being shared with the
9 Managed Care Organizations on how do we ensure that
10 members are getting to appointments for the care that
11 they need.
12 DR. BOBROWSKI: This is Dr.
13 Bobrowski. May I make a comment?
14 MS. CECIL: Of course.
15 DR. BOBROWSKI: In the dental
16 arena, these failed and missed appointments is a huge
17 factor. And I know going to the dentist isn't a lot
18 of fun. It's not as fun as I told a guy yesterday of
19 going fishing or playing with grandchildren.
20 We set up times for people to
21 come in, as you all do, and, then, we'll make
22 appropriate referrals sometimes to oral surgeons.
23 And the oral surgeons around here and across the
24 state, a lot of them are booked out until October and
25 November. And, then folks will have appointments

1 that we try to get them in pretty quick for surgical
2 extractions and they just don't even show up at the
3 specialist's office.
4 And we tell them, you've got to
5 keep these appointments or you may not be able to get
6 back in at that oral surgeon's office.
7 So, I just wanted to give
8 everybody a shout-out that in the dental arena, it's
9 a big problem but that's all I've got to say. Thank
10 you.
11 MS. CECIL: Thank you.
12 DR. PARTIN: Veronica, did you
13 see that question from Emily Beauregard about
14 transportation, if transportation is an issue?
15 MS. CECIL: Transportation is on
16 the list and it is - for cancelled appointments, it's
17 about the fourth down on the list. For missed
18 appointments, it's also about fourth on the list but
19 pretty far behind those others.
20 And, again, it's unfortunate
21 that they're getting bucketed into Unknown or Other
22 because that doesn't give us a lot of information,
23 and those are by far the largest buckets that
24 providers are indicating.
25 And I get it because sometimes

1 the provider may not know, and, so, they want to
2 report the appointment being missed or cancelled
3 which, again, is good information for us, but being
4 able to distill it down to exact reasons is always
5 going to be more helpful.
6 I will say, Dr. Bobrowski, we
7 have some dentists on the list but they're pretty far
8 down. Our largest reporting is in behavioral health
9 and in primary care. By far, those two are our
10 largest reporting.
11 DR. BOBROWSKI: At our office
12 here, we did a report of all the missed appointments,
13 and you know how it goes in cycles. Some days you
14 might have one or two, but, then, I think it was last
15 Wednesday, I had eight to just not even show up.
16 I hate to be hard on it but a
17 lot of offices, you miss one or two appointments and
18 you're just dismissed. And I hate it for the people,
19 but, at the same time, it's, like, they've got to
20 learn to get with the program and especially when
21 they're missing their specialists' appointments that
22 we send them to.
23 I was one of the new providers,
24 I guess. We did it for about a month, and the other
25 thing is, like, a lot of offices, they're so busy

1 trying to still get caught up from COVID, that some
2 of them are just saying, well, I just don't have time
3 to do one more thing for Medicaid in terms of having
4 their staff file that report. Even though it's not a
5 lengthy process, it's just one more thing to do.
6 So, it's just a problem. I
7 don't know. I wish we could figure out something but
8 behavioral management is the whole key to all of
9 this. Thank you.
10 MS. CECIL: Absolutely. And I
11 see that request in the Chat and we will certainly
12 add the link to the information about how to record
13 those missed appointments.
14 DR. PARTIN: I'd like to make a
15 couple of comments and observations.
16 First of all, in 2009, out of
17 all Medicaid providers, that's not a very high number
18 of provider offices reporting; but on the converse
19 side of that, over 6,000 reports just from 209
20 providers is pretty significant.
21 And, then, the other thing
22 about the Unknown, what we find at our clinic is that
23 they don't show up and we can't reach them to find
24 out why they didn't show up. So, that would go into
25 the Unknown category and it's very frustrating.

1 I think some people use cell
2 phones that they purchase at Walmart and, then, when
3 that phone runs out of minutes, they discard the
4 phone and you can't even reach the people. So, a lot
5 of issues there that confound this problem, I think.
6 MS. CECIL: Right. I understand
7 that. So, I'm happy to take any other questions or
8 comments around missed appointments; but if not, we
9 have a couple of other updates we want to provide.
10 We did set our open enrollment
11 dates. We wanted to share those. It will be October
12 15th through December 1st.
13 Now, two other things that we
14 wanted to provide updates on are regulations, and I'm
15 going to turn it over to Jonathan Scott for him to
16 update you on where we are with the regulations, and,
17 then, Pam Smith is going to give an update on the
18 HCBS spending plan for the American Rescue Plan
19 funds.
20 MR. SCOTT: Good morning,
21 everyone.
22 MS. HUGHES: Jonathan, before
23 you start, TAC members, could you all please start
24 your video so that you're visible. Thank you.
25 Sorry, Jonathan.

1 MR. SCOTT: No problem. Good
2 morning, everyone. I wanted to tell you that we have
3 five regs right now that are filed.
4 So, the first one is the
5 implementing reg for Senate Bill 50. That reg is 907
6 KAR 23:020 and we also filed an emergency reg on
7 that. So, it could be our first reg that has the
8 dual public comment hearing possibility where we
9 could have a hearing on it next month and a hearing
10 on the ordinary version of the reg the month after
11 that. So, that's going on right now.
12 That reg clarifies dispensing
13 fees, when a dispensing fee is eligible to be
14 reimbursed, just a little bit of a cleanup to let us
15 smoothly implement Senate Bill 50.
16 We also have a group of two
17 regs that is part of the anesthesiology under medical
18 direction. We have recently riled a Statement of
19 Consideration. We also amended one of the regs after
20 comments.
21 Those regs are currently
22 scheduled to be heard at the August ARRS meeting, the
23 amended and one of them we didn't amend, and that's
24 907 KAR 3:005, 907 KAR 3:010, Physician Services and
25 Physician Provider Services Reimbursement.

1 We have also filed 907 KAR
2 3:060 which is an ambulance provider assessment. We
3 got some comments on that reg. So, we are currently
4 preparing a Statement of Consideration for that that
5 we'll file by the middle of next month.
6 And, then, we also have 907 KAR
7 1:038 that is our hearing program reg. That reg
8 allows for individuals over the age of twenty-one to
9 be seen by an audiologist for evaluation and testing
10 purposes only, and we also, for all recipients, an
11 office visit to a physician is not needed before the
12 referral can be made to an audiologist.
13 A couple of noteworthy regs
14 that may be filed soon - 907 KAR 1:604 which is our
15 copay reg. We will be amending that to comply with
16 the passage of Senate Bill 55 from this last Session,
17 and, then, 907 KAR 3:170 which is our telehealth reg
18 which we will be amending to comply with the passage
19 of House Bill 140.
20 That's all I have, just a light
21 review of some of the regs going on. I'd be happy to
22 answer any questions you may have.
23 DR. PARTIN: Jonathan, the
24 second reg, was that 703 KAR 3:160?
25 MR. SCOTT: 907 KAR 3:060 is the

1 ambulance provider assessment reg.
2 DR. PARTIN: 907. Okay. And
3 the first one is 703. Is that right?
4 MR. SCOTT: No. All of our regs
5 are 907 and, then, KAR. The pharmacy reg is 23:020
6 and, then, the anesthesiology under medical direction
7 regs are 907 KAR 3:005 and, then, the other one is
8 907 KAR 3:010.
9 DR. PARTIN: Okay. All right.
10 MS. EISNER: Could you talk a
11 little bit about the telehealth regulation amendments
12 that you're expecting to make?
13 MR. SCOTT: So, we will be
14 looking to comply with House Bill 140. So, I think
15 you can expect some of the things like the
16 introduction of remote patient monitoring, the
17 originating site fee that was required by that bill.
18 There's some other
19 housecleaning where we're going to be just referring
20 to some other regulations, some other definitions,
21 some things like that. Then, there's just a group of
22 some policy changes that are still kind of at the
23 departmental level that we are continuing to discuss
24 internally. So, there will be more on that in coming
25 months.

1 MS. EISNER: Thank you.
2 MS. CECIL: And, Nina, since you
3 asked the question, and we do want to talk a little
4 bit about telehealth, we have some flexibility right
5 now under the Public Health Emergency, which, by the
6 way, as part of my update, I should have said has
7 been extended for another ninety days. So, we were
8 very pleased to see that the Administration took that
9 step.
10 As we unwind from those
11 flexibilities, one thing that we're going to really
12 need to talk to the licensing boards and the
13 professional associations about is when can an out-
14 of-state provider deliver telehealth services to an
15 in-state Kentuckian and how do we monitor that and
16 track that within our system because right now some
17 of the licensing boards aren't allowing that but we
18 kind of have to see what happens as we move out of
19 the current Public Health Emergency, and, then,
20 understanding, because every licensing board is
21 different, are we accurately capturing that because
22 we certainly don't want to cover a service that's not
23 appropriate.
24 So, if you all could be
25 thinking about that. We have a plan to try to reach

1 out to the different professional licensing boards
2 and get them involved in that conversation because
3 communication will be key, especially from the
4 perspective that we need to know what those boards
5 and agencies are going to do in the future around
6 delivering that service.
7 Thank you for that reg update,
8 Jonathan. And if there aren't any other questions
9 about regulations, I will turn it over to Pam to give
10 an update on the American Rescue Plan HCB funds.
11 MR. MARTIN: Veronica, this is
12 Barry. Has there been thought about with the
13 telehealth regulations maybe requiring an on-site
14 visit, an in-person visit every third visit or fourth
15 visit because that, then, would help the out-of-state
16 providers to have some kind of connection with the
17 patient because I'm also afraid that not having that
18 on-site or hands-on visit is going to cause a lot of
19 issues and also compromise care in the long run.
20 MS. CECIL: So, that's some of
21 the issues we're getting into is what should we
22 require.
23 And the other thing we wanted
24 to make very clear is that we're not necessarily the
25 arbitrator on what should be face-to-face and in

1 person, I mean, what should be face-to-face and
2 telehealth. It's really the professional standards
3 because we knew when we went to telehealth quickly in
4 March of last year that there were some licensing
5 boards and professional standards that had to be
6 changed because they had required the service to be
7 face-to-face.
8 And, so, what we want to make
9 sure is what is appropriate and, so, we're having
10 those conversations.
11 DR. PARTIN: Veronica, in
12 regards to the emergency orders, since the federal
13 order was extended for ninety days, does that mean
14 all of the current state emergency orders will remain
15 in place for ninety days?
16 MS. CECIL: So, there is
17 definitely a difference between the Public Health
18 Emergency and the state emergency and I don't have -
19 I apologize - all of the information around the state
20 emergency order; but what I can tell you from a
21 Medicaid perspective, all of the flexibilities that
22 we implemented were tied to the Public Health
23 Emergency.
24 So, in terms of what might be
25 happening at the state level, the Medicaid

1 flexibilities remain in place.
2 DR. PARTIN: Thank you.
3 MS. CECIL: If there aren't any
4 other questions around that, I'll turn it over to
5 Pam.
6 MS. SMITH: Thank you. So, we
7 submitted our initial spending plan and our initial
8 narrative to CMS on July 12th. We had applied for
9 and received approval for the initial extension as
10 they were due originally in June; but as most other
11 states did, we received approval for that extension.
12 And CMS has promised as quick
13 of a turnaround on those as possible. Those initial
14 narratives and spending plans were at a very high
15 level; but to give you an idea of the priorities that
16 we looked at, we wanted to invest in provider and
17 workforce development, service access, crisis
18 services, technology and transformation, and, then,
19 also have a component of project management and
20 administrative support as there is a significant
21 amount of reporting that we have to do to CMS as we
22 go through this process. There are quarterly reports
23 due where at each time we will actually refine
24 spending plans and give updates on the work that
25 we're doing.

1 So, for workforce and provider
2 development, we wanted to focus on, number one,
3 trying to help stabilize the workforce, so, looking
4 at can we create some funds for some bonuses or for
5 some immediate money to infuse into the providers to
6 help stabilize the workforce, as well as looking at
7 longer-term solutions on how can we grow the
8 workforce, what can we do as far as training, what
9 can we do as far as recruitment to help providers.
10 We have heard that they may
11 have individuals that apply for jobs but they don't
12 show up to the interview. So, how can we work with
13 the providers to help with that?
14 Is it possible to develop a
15 tract even within the high school system and the
16 vocational programs that's similar to the CNA tract
17 but that really focuses on the direct support
18 professional. That job is a little bit different in
19 that you really are very engaged in the individual
20 that you're caring for and advancing what their goals
21 are and their community integration.
22 Looking at technology
23 solutions. Can we help develop a registry that would
24 help for recruitment, and that also is on the
25 Participant-Directed Services' side. So, it would

1 have one central point that if you're looking to hire
2 an employee, that you could come and review basically
3 on a registry individuals that have already had their
4 preemployment screenings done and that they are
5 looking for a job in this field to try to shorten the
6 time that it takes.
7 Advancing our training.
8 Training is always important. We're learning
9 constantly. So, how can we advance our training?
10 We wanted to look at easing the
11 access to HCB. So, how can we strengthen our no-
12 wrong-door approach so that when individuals come in
13 and they apply for Medicaid or they come in seeking
14 some type of benefit, how do we screen them to make
15 sure that they need maybe assistance with utilities?
16 And while that's not something
17 Medicaid pays for, how can we connect them to the
18 social resources that will help that? How can we
19 potentially delay the need for those more in-depth
20 services or those skilled services? How can we help
21 them where they are and to continue to help them to
22 age in place, so, really looking at taking a holistic
23 view of the individuals.
24 We also are wanting to look at
25 our wait list. What can we do for the wait list? We

1 have a significant wait list for Michelle P. How can
2 we get the individuals that are on that wait list,
3 are there services that we can connect them with
4 right now that either will meet their needs or that
5 will take care of any imminent needs until they have
6 a spot?
7 We want to go back and look at
8 our rates and our current service menu. We know that
9 rates are an issue. We have begun the rate study.
10 With part of the waiver redesign efforts, we want to
11 go back and revisit that and really see what can we
12 do to make sure that there's, number one, quality
13 among the rates and that the rates are high enough
14 that we can keep employees and we're not frankly
15 losing employees to McDonald's or to Amazon.
16 We also want to look at our
17 crisis services. So, how can we support the acute
18 and transition services, some of the mobile-based
19 crisis services, the 988 crisis response line, so,
20 working with Behavioral Health to support that
21 initiative and how we can help that.
22 We also want to do a couple of
23 feasibility studies to look at what will it take and
24 can we implement an SMI and an SED waiver, also
25 looking at chronic disease management and a waiver

1 that would support children.

2 So, with those funds, we are

3 hoping that we can do those feasibility studies to

4 find out what services would be best, what type of

5 funds we would need to allow us to be able to offer

6 those funds.

7 So, we're hoping to hear back

8 within a couple of weeks back from CMS; but in the

9 meantime, we are developing an overall project plan,

10 looking at what the next step will be immediately as

11 soon as we hear back from CMS.

12 Stakeholder engagement will be

13 a very important piece that will be strong throughout

14 whatever projects that we do implement.

15 So, once we have our approval

16 from CMS, we will begin scheduling some of those

17 sessions with stakeholders. It will include

18 providers and advocates, as well as individuals

19 receiving services or individuals on wait lists and

20 the people that support them to really get their

21 feedback and to engage them to be with us throughout

22 this whole process.

23 So, I'll take any questions if

24 anybody has any questions.

25 DR. PARTIN: Pam, would it be

1 possible for you to share your document with the MAC
2 or even put it out publicly?
3 MS. SMITH: I can. Yes. I can
4 send it to Sharley to share. We are going to put it
5 on the website. We just had not got that far yet but
6 absolutely I can share the plan that we submitted.
7 DR. PARTIN: Great. Thank you.
8 MS. CECIL: And those are the
9 updates that we had planned to share today. I'm
10 happy to take any questions.
11 DR. HANNA: Veronica, I don't
12 have a question. This is Kathy. I just wanted to
13 reiterate that the overall transition to the single
14 PBM, MedImpact, has gone very well, as well as could
15 be expected based upon what we had to do, right?
16 So, a few hiccups but everybody
17 is working through it real well and I just wanted to
18 thank the Department for Medicaid Services and also
19 MedImpact for all of their efforts at making this go
20 forward. Thank you.
21 MS. CECIL; Thank you so much
22 for sharing that. It is always good to hear good
23 news.
24 DR. PARTIN: Okay. If there's
25 no other questions, then, we will move on. Thank you

1 for all of that information. We appreciate it.

2 MS. CECIL: You're welcome.

3 DR. PARTIN: So, next up are

4 reports from the TACs and recommendations, and we

5 will start with Behavioral Health.

6 DR. SCHUSTER: Good morning.

7 Sheila Schuster, Chair of the Behavioral Health TAC.

8 We met on July 7th and we have

9 a new voting member per House Bill 53, Diane Schirmer

10 representing the Brain Injury Association of America

11 - Kentucky Chapter.

12 So, all seven of our voting TAC

13 members were there. We also had representatives from

14 Medicaid and from Behavioral Health and a big number

15 of people from the behavioral health community.

16 I think I mentioned at our last

17 report that we are working very closely with

18 Commissioner Lee and with the data people at DMS to

19 pull data on targeted case management and the first

20 phase of that has been completed by the data folks.

21 We're focusing on adults with

22 severe mental illness which is a group that I've

23 probably spoken to the MAC about more often than

24 anything, and they've identified slightly over 8,600

25 people that would fit our criteria of people with an

1 SMI diagnosis who have received targeted case
2 management in a six-month period. So, we’re very
3 excited to actually have some data to look at what
4 the effects of targeted case management are.
5 We were very pleased to have
6 Dr. Fatima Ali on from the Pharmacy Department and we
7 talked through the transitions, a few hiccups still
8 on the single Formulary but certainly not what we had
9 been experiencing before.
10 And apparently the transition
11 to the new PBM has gone well, so, I appreciate that
12 and appreciate Deputy Commissioner Veronica Cecil for
13 kind of being a liaison there. We appreciated Dr.
14 Ali being on.
15 We did have one issue around
16 lockouts for a particular pharmacy or a provider. We
17 had a psychiatrist who is out in the community who
18 had some folks that were in Medication-Assisted
19 Treatment in an agency but the prescriber changed and
20 they got locked out because the prescriber changed.
21 And, so, Dr. Ali was very helpful, I think, in giving
22 him some solutions for that.
23 We continue to have a big
24 problem and this is not, I’m sure, just in behavioral
25 health but it’s around dual eligibles. So, those

1 people who have both Medicaid and Medicare or who
2 have Medicaid and some private insurer.
3 And we had several DMS staff
4 members that were there that were very helpful to us,
5 Angie Parker and Lee Guice, and I think we're making
6 some headway on this, but we're going to come back to
7 it at our next meeting just to be sure.
8 For a long time, people who had
9 two payer sources, we had more trouble getting
10 payment if they had two payer sources than if they
11 only had one which really makes no sense.
12 I want to talk a minute or two
13 about the no-show or the missed appointments because
14 we've raised some issues of concern. We don't want
15 Medicaid recipients, particularly those with
16 behavioral health diagnoses, to get labeled somehow
17 as bad clients or chronic no-shows and so forth.
18 So, we were asking some
19 questions about how that data was reported to the
20 MCOs, how frequently it was being gathered and what
21 format it was being reported, and we're going to get
22 a report back in September.
23 We also had heard from a number
24 of providers that it was kind of clunky or not a
25 smooth and quick process sometimes to enter the data.

1 So, we've asked them to look at that as well.
2 We're always checking on the
3 SUD waiver for persons who are incarcerated. And,
4 unfortunately, there's been no change because of the
5 slowness with which CMS in D.C. is getting new staff
6 on board.
7 There is a House Joint
8 Resolution 57 Task Force that's meeting for those of
9 you who are interested in what we call the benefits
10 cliff, people that fall off coverage without having
11 any way of being covered until they get another plan,
12 and we're very pleased that the Cabinet has pulled
13 together a workforce to look at that.
14 There are several interim
15 committees that are of interest to behavioral health.
16 There's one on individuals with severe mental
17 illness. There also is the 1915(c)Home- and
18 Community-Based Task Force that has been meeting.
19 So, we're very pleased about that.
20 And we were very pleased that
21 the ABI folks were able to sit down with leadership
22 at Medicaid and at the Department for Aging and
23 Independent Living and come up with some next steps
24 on implementing some of their recommendations. You
25 all will remember that we submitted those to the MAC

1 last meeting time.
2 So, we have no recommendations
3 and our next meeting will be September 1st, and we do
4 appreciate having this format for talking about
5 behavioral health. Thank you.
6 DR. PARTIN: Thank you, Sheila.
7 Next up is Children's Health.
8 MS. HUGHES: Beth, I'm sorry.
9 They did not meet.
10 DR. PARTIN: Okay. Thank you.
11 Consumer Rights and Client Needs.
12 MS. BEAUREGARD: Good morning.
13 Emily Beauregard. I'm the Director of Kentucky Voices
14 for Health.
15 We met on June 15th and we met
16 remotely using Zoom. We had a quorum present.
17 First, I just want to say thank
18 you to Dr. Partin and other TAC members for making
19 the recommendation during May's MAC meeting to share
20 publicly the video recordings of MAC and TAC meetings
21 when they are recorded.
22 I also want to thank
23 Commissioner Lee for accepting that recommendation.
24 I think this is a really great opportunity to make
25 MAC and TAC meetings more accessible not only to

1 members who may miss the meeting for one reason or
2 another but also for Medicaid members and for the
3 general public who may have a conflict during that
4 time and need to catch up on that later.
5 So, I've heard that if we go to
6 some sort of hybrid schedule where some of us meet in
7 person, others might want to meet remotely but there
8 may not be the equipment right now to support that,
9 but I do hope that DMS will be able to invest in some
10 equipment so that we can have those hybrid meetings
11 and still have that remote option and can be recorded
12 because I really think that it's just a great
13 opportunity for more accessibility and transparency,
14 and I think it's worked really well for us to have
15 that additional option.
16 So, during our June meeting, we
17 discussed a number of our usual issues that we've
18 presented to you before - presumptive eligibility,
19 coverage options for immigrants, updates on our
20 1915(c)waiver programs, SUD services and reentry
21 supports.
22 We also discussed the rollout
23 of the new single Pharmacy Benefit Manager, the PBM,
24 as well as opportunities to expand postpartum
25 coverage and the Home- and Community-based Services

1 that have been made possible through the American
2 Rescue Plan Act.
3 So, we were really glad to
4 learn more about the work that DMS is doing to
5 improve child and maternal health through the
6 Perinatal Quality Collaborative. I think that's very
7 valuable.
8 In particular, we were excited
9 that DMS is seriously exploring the option to submit
10 a State Plan Amendment to extend postpartum coverage
11 from what is currently two months postpart to twelve
12 months. This is particularly important for moms with
13 incomes that are just above the 138% of the Federal
14 Poverty Level.
15 That's the typical cap on
16 enrollment or on eligibility, and it's one of the
17 many ways that we can begin to address health
18 disparities that have been caused by systemic racism.
19 So, we very much support that and hope that it moves
20 forward.
21 After years of discussing
22 barriers to healthy reentry, we really appreciate
23 that DMS has created a new MAP form that people who
24 are no longer incarcerated can use to lift their
25 suspension status and activate their Medicaid

1 coverage.

2 This has been an issue I guess

3 for years where people are released from

4 incarceration but their Medicaid stays in a suspended

5 status which means that they can't get the coverage

6 or the services that they need to support perhaps

7 their recovery and just generally their health.

8 So, this is particularly

9 important, of course, for people who need access to

10 behavioral health and SUD treatment.

11 Now, this form isn't necessary

12 for every person who leaves incarceration. Some

13 people, their suspension gets lifted in the way that

14 it should initially; but for those who, the date

15 isn't updated in the system in a timely fashion or

16 something gets entered incorrectly, this form gives

17 the individual or their authorized representative the

18 ability to fix that problem.

19 We're not sure yet how well

20 it's working but we're monitoring this closely,

21 talking to community health workers and Connectors

22 and trying to make sure that people are aware of the

23 form.

24 And, finally, we discussed the

25 rollout of the single PBM. We're really happy to

1 hear that so far things have been going well and we
2 certainly haven't been hearing of issues that people
3 have experienced yet.
4 I think the targeted outreach
5 that DMS has planned for members and just the
6 planning that has been done in advance of the rollout
7 has probably made it much smoother than it could have
8 gone. And, so, we appreciate all of the work that's
9 gone into that.
10 I do think that because we're
11 in this grandfather period of people having ninety
12 days essentially since July 1st for prescriptions
13 that have been grandfathered in that may no longer be
14 on the Preferred Drug List, right now we're probably
15 not seeing some of the issues that we may see at the
16 end of that period which I think would be at the end
17 of September.
18 So, we're going to be
19 monitoring that as well. I just want to make sure
20 that every Medicaid member knows that there could be
21 some changes coming to that Preferred Drug List and
22 that there may be some prior authorizations required
23 for things that didn't require a PA in the past. So,
24 just important information for providers to be
25 sharing with their patients as well.

1 We had one recommendation from
2 our June meeting which was that DMS customize a PBM
3 letter targeted to impacted Medicaid beneficiaries
4 that includes the names of medications that will now
5 require a prior authorization.
6 DMS already had a letter
7 planned but not with information about specific
8 drugs. So, we thought including that specific
9 information would be helpful to the member.
10 And, then, our next meeting
11 date is going to be August 17th at 1:30 and we'll
12 have new members joining us at that time and that's
13 all I have. Thank you.
14 DR. PARTIN: Thank you, Emily.
15 Dental TAC.
16 DR. BOBROWSKI: Yes. This is
17 Dr. Bobrowski. Our next meeting is August 13th.
18 I know that we brought up in
19 the past the issue of a soda tax, and the KDA has had
20 numerous meetings on this and we have an Executive
21 Board meeting this Saturday and this topic will be
22 brought back up again.
23 So, other information will come
24 forward on that and there's pros and cons on anything
25 like that, especially when you're trying to maybe

1 change behavior but at the same time it is a tax and
2 we would all have to pay it.
3 A lot of discussion this
4 morning has been on these prescriptions and stuff,
5 and Kentucky is not too bad just yet, but I know one
6 thing to kind of keep on our radar is the State of
7 Pennsylvania, it costs dentists right at $3,000 a
8 year just to be able to do their electronic
9 prescriptions.
10 So, please, let's all work
11 together. Don't let that happen in Kentucky. There
12 is a fee for us to do that but it's nowhere near
13 that.
14 And I did have one question for
15 Dr. Schuster. I was going to ask you about what you
16 felt like your outcome was when you had your meeting
17 with the Medicaid Oversight and Advisory Committee,
18 if that's okay to ask on a TAC report?
19 DR. SCHUSTER: I testified about
20 the suspension of prior authorizations for behavioral
21 health and there was no action taken because they're
22 in the Interim Session, Dr. Bobrowski, so, they can't
23 do anything, but certainly the comments from I think
24 almost every one of the members of what we call the
25 MOAC, the Medicaid Oversight and Advisory Committee,

1 was very positive about maintaining those
2 suspensions.
3 The recommendation I made was
4 that they be maintained at least until the end of the
5 year when we're kind of out of the COVID impact
6 hopefully and we have some more of this data that
7 we're collecting. So, thank you for asking.
8 DR. BOBROWSKI: That is all the
9 Dental TAC has to report for today. Thank you all.
10 DR. PARTIN: Thank you. Nursing
11 Home.
12 DR. MULLER: It's John Muller.
13 Our TAC Chairman, Terry Skaggs, had an unexpected
14 emergency. So, I'm the MAC member but I'd like to at
15 least read this in for Terry.
16 The Nursing Home TAC met on
17 Wednesday, June 30th, attended by most of the TAC
18 members. Agenda items discussed included whether or
19 not future meetings are virtual versus the in-person
20 and we will keep going forward with the virtual
21 format.
22 The Department for Medicaid
23 provided an update on the funds paid to date for the
24 $270 COVID add-on per day and the additional bed
25 reserve payments that were part of the COVID

1 emergency.
2 TAC members were also able to
3 confirm the normal rate inflationary adjustments that
4 will be made to the price of 1.09% and 2.5% for the
5 capital and the non-capital components respectively
6 effective July 1st, '21.
7 TAC members also discussed the
8 efforts made by the Association to affect changes to
9 Medicaid eligibility, the policy to more closely
10 align with the way other states grant Medicaid
11 eligibility for long-term care. DMS agreed to review
12 the documents provided by the TAC and have responded
13 to the Association and we are going to work together
14 to adopt the policies where practicable.
15 We also discussed the new
16 hybrid, very important to us, level-of-care process
17 that would include obtaining a sample of residents
18 and, then, a 90% or more accuracy threshold, and if
19 we pass the threshold, level-of-care testing would
20 only occur once per year.
21 After discussion, the TAC had
22 several questions regarding this new Carewise level-
23 of-care implementation including what action is going
24 to occur if the facility does not meet the 90%
25 accuracy of the sample. Will the facility be

1 provided a list of the sample residents prior to the
2 onsite review?
3 And as of the initial approval,
4 after review of the KLOCS' information, we only have
5 a 30-day window. If reviews are only going to be
6 yearly, we need it clarified, how will the extension
7 process work if it's several months between the
8 required assessment of the KLOC and, then, the yearly
9 review?
10 DMS answered the questions
11 during the TAC but we are going to need further
12 followup at our next TAC meeting from DMS on those.
13 And, lastly, we had a
14 discussion of the MAP-350 provider letter
15 implementation. We greatly appreciate the
16 Department's removal of the requirement to obtain
17 signed and dated signatures annually and also had a
18 discussion of what's going to happen to Medicaid
19 recertifications once the PHE ends if we, as noted
20 earlier, have a bit more time with the extension
21 signed earlier this week.
22 That concludes Chairman Skaggs'
23 report from the Nursing Home TAC. Thank you.
24 DR. PARTIN: Thank you. Home
25 Health.

1 MS. HUGHES: The Home Health TAC
2 did not meet, Dr. Partin.
3 DR. PARTIN: Okay. Thank you.
4 Hospital.
5 MR. RANALLO: This is Russ
6 Ranallo, Chair of the Hospital TAC.
7 The Hospital TAC met on June
8 22nd. We had a quorum. We don’t have any
9 recommendations.
10 Some of the items that we
11 talked about, we talked about the WellCare short stay
12 policy. WellCare put out a policy that was approved
13 by DMS that basically said, outside of a few
14 exceptions, anytime a patient came in to the hospital
15 and had any stay less than two days, they were to be
16 considered observation regardless of whether they met
17 the medical necessity criteria to be an inpatient.
18 Numerous hospitals, once they
19 saw the policy, had issues and questions. For
20 example, it wasn’t clear what populations the policy
21 applied to. OB and newborn very often have a stay of
22 two days or less and would they be observation and
23 not inpatients?
24 The policy was rescinded, sent
25 back to WellCare. WellCare revised the policy and

1 sent it back to DMS and we raised concerns that the
2 policy was against information in the regulation but
3 also maybe in the contract between WellCare and the
4 State.
5 The Hospital Association had a
6 meeting after the TAC meeting with DMS and went over
7 our concerns. The policy is still in draft form, as
8 I understand it.
9 We talked about the WellCare
10 NICU policy, another policy where WellCare would
11 reduce outlier payments when the hospital billed a
12 level of care that did not match the level of care
13 authorized or approved by the WellCare vendor,
14 Progeny.
15 We talked about the
16 administrative burden and the reduction of payments
17 and that no other MCO or really any other insurance
18 plan has this type of policy for an inpatient baby.
19 The psych hospital EMTALA
20 requirements, you heard that earlier in the meeting.
21 The other items, we agreed to continue to Zoom meet
22 for the remainder of the year and, then, Bud Gorman
23 with KHA talked about the KHA Patient Transport
24 Committee.
25 Large parts of the hospitals

1 are reporting having issues with non-emergent
2 transport and getting patients to the proper level of
3 care resulting in delays of care on occasions and
4 also using transports that are more expensive,
5 whether it's fixed wing or helicopter.
6 The next Hospital TAC meeting
7 will be August 24th. Thank you.
8 DR. PARTIN: Thank you. Next
9 up, Intellectual and Developmental Disabilities.
10 MS. HUGHES: They did meet but
11 there were no recommendations. I haven't seen
12 anybody on here to tell you that.
13 DR. PARTIN: Okay. Thank you.
14 Nursing TAC.
15 MS. HUGHES: They did meet last
16 month. It was more of an organizational meeting and
17 appointing the Chair and so forth. So, they didn't
18 have any actual report to make today.
19 DR. PARTIN: Thank you.
20 Optometry.
21 DR. COMPTON: Steve Compton. We
22 have not met since the last MAC meeting. We're
23 scheduled to meet again on August 5th. So, we have
24 no report.
25 DR. PARTIN: Thank you.

1 Pharmacy.

2 MS. HUGHES: Pharmacy did not

3 meet either.

4 DR. PARTIN: Okay. Physician

5 Services.

6 DR. McINTYRE: This is Dr.

7 William McIntyre. I'm Vice-Chair of the Physician

8 TAC.

9 We met six days ago, July 16th.

10 We had a number of discussions. We're going to have

11 in-person meetings every third meeting. So, the next

12 in-person meeting that we'll have will be in

13 November.

14 We discussed the soda tax; and

15 while we don't have a recommendation on that, we want

16 Dr. Bobrowski and his TAC to know that the Physician

17 TAC fully supports using a soda tax to try and

18 influence consumer behavior to reduce the intake of

19 soft drinks.

20 We do have one recommendation.

21 We discussed Medicaid limits on complex evaluation

22 and management office visits in chronic care

23 management, and there's a KAR regulation, 907 KAR

24 3:010(10), and this regulation limits Level 4 and

25 Level 5 office visit reimbursement.

1 The regulation says that 99214
2 and 99215 shall be limited to two per recipient per
3 provider per calendar year.
4 Our concerns are, first of all,
5 the reimbursement for those levels is already well
6 below the reimbursement for the same levels by
7 surrounding states.
8 And, second, physicians and
9 other providers have to learn the CPT codes, apply
10 them correctly and that's frustrated by having the
11 CPT codes automatically reduced if it's been more
12 than two visits in that calendar year that have had
13 those higher levels.
14 Also, a lot of our patients are
15 elderly. Their care is complex and having the limits
16 on the codes that are used, the code for those
17 complex visits defeats the purpose of having those
18 codes in the first place.
19 And, third, with the limited
20 reimbursement for those codes and with the limitation
21 on only having two of those high Level 4 and Level 5
22 visits a year, this interferes with the efforts to
23 recruit physicians to come in to the state.
24 So, our recommendation is that
25 the limits to two Level 4 and Level 5 visits a year

1 per recipient, that that be eliminated and that sums
2 up our meeting and our recommendations.
3 DR. PARTIN: Okay. Thank you.
4 Next up is Podiatry.
5 MS. HUGHES: They did not meet.
6 DR. PARTIN: Okay. Primary
7 Care.
8 MR. MARTIN: This is Barry
9 Martin. I'm a member of the Primary Care TAC, and
10 our Chair, Mike Caudill, was unable to participate in
11 the MAC call. So, I will give the report.
12 We met on July 1st and we did
13 not have any recommendations. However, we did
14 discuss having a hybrid meeting for our next meeting
15 where we would have the option to meet in Frankfort
16 at the Kentucky Primary Care Association office for
17 the TAC members or have it via Zoom and, then, we
18 would meet via Zoom with the DMS members for our next
19 meeting which is September 2nd, and that's all I have
20 to report.
21 DR. PARTIN: Okay. Thank you.
22 And last, Therapy Services.
23 MS. HUGHES: They did meet but
24 it doesn't appear that there's anyone here from that
25 TAC but there were no recommendations.

1 DR. PARTIN: All right. There
2 were none?
3 MS. HUGHES: There were none,
4 no, ma'am.
5 DR. PARTIN: Okay. Thank you.
6 So, that concludes the reports and recommendations
7 for the TACs.
8 Would somebody like to make a
9 motion to accept the recommendations?
10 DR. GUPTA: I move. Dr. Gupta.
11 MR. WRIGHT: Second. Eric
12 Wright.
13 DR. PARTIN: Any discussion?
14 All in favor, say aye. Any opposed? Okay. The
15 recommendations are accepted.
16 Then we move on to New
17 Business. Before we do New Business, Deputy
18 Commissioner Cecil had something else she wanted to
19 report to us.
20 MS. CECIL: Thank you, Dr.
21 Partin. I can't believe I forgot to mention this,
22 especially with the discussion around Senate Bill 50,
23 but I did want to announce that Dr. Fatima Ali who
24 has been serving as an Associate Pharmacy Director
25 has been essentially named our Acting Pharmacy

1 Director.

2 And I can assure you that the

3 success of Senate Bill 50 is due to her hard work. I

4 really can't take any credit. She was just amazing

5 and phenomenal and made sure that things went

6 smoothly.

7 So, I just wanted to announce

8 to everybody that Dr. Ali will be stepping in as

9 Acting Pharmacy Director, and we do plan to hire two

10 Clinical Managers that will help us manage both the

11 Managed Care side and the fee-for-service side.

12 Thank you.

13 DR. PARTIN: Thank you. To New

14 Business, I have two items under New Business.

15 One, I was wondering if DMS can

16 tell us, of course, not today, but give us some idea

17 about the COVID vaccination rate for Medicaid

18 recipients. Would that be possible?

19 MS. CECIL: Absolutely. We are

20 tracking it and, you're correct, I don't have it at

21 the top of my head right now but we are absolutely

22 tracking it. I'll be more than happy to provide

23 that.

24 DR. PARTIN: Okay. So, I'll put

25 that on for the next meeting.

1 And, then, the next item for
2 New Business is to discuss whether we want to
3 continue the Zoom meetings or in-person meetings or
4 some kind of mixture of that.
5 I would like to recommend at
6 least for our next meeting that we continue with Zoom
7 just because of the Delta variant surging right now,
8 but I'm open to any discussion or comments on that.
9 MR. ESSEK: If I may. I'd like
10 to see at least a hybrid type of meeting.
11 DR. PARTIN: I couldn't hear
12 you. I heard that you said some kind of hybrid.
13 MR. ESSEK: Yes, ma'am. Daniel
14 Essek, Peer Support. I would like to see some type
15 of hybrid meeting where even if it's in-person, that
16 there be a Zoom component of it.
17 DR. PARTIN: Is that possible,
18 Deputy Commissioner?
19 MS. CECIL: We've expressed this
20 with each of the TACs that we are concerned about the
21 availability of meeting rooms that can accommodate
22 both an in-person and a virtual.
23 Part of that is because, as you
24 noted with the variant, we remain concerned about
25 having the availability for as many people that want

1 to attend in person and ensuring the safety.
2 So, we're certainly leaving it
3 up to you all to make the decision on what you want
4 to do and we'll work towards that. We do need, I
5 think, some time to figure that out if we wanted to
6 move to a hybrid, and I do recommend a hybrid
7 because, as you can see with the number of attendees
8 we have today, this has certainly opened up the
9 ability for more participation which is wonderful.
10 So, if we wanted to move to
11 hybrid, I'm not sure if we could do it by the next
12 meeting but certainly we'd be happy to work towards
13 that.
14 DR. PARTIN: Okay. So, as far
15 as the MAC goes, for our next meeting, are you all in
16 agreement that we meet virtually for our next
17 meeting?
18 (TAC members in agreement)
19 DR. PARTIN: Okay. And, so, we
20 can discuss that further, then, at our next meeting
21 in September of how we want to proceed. Does that
22 sound okay to you all?
23 (TAC members in agreement)
24 MS. HUGHES: Dr. Partin, one
25 other thing, too, is that the meeting room that you

1 all were using, if all the MAC members attended, was
2 crowded to get you all all at the table and you've
3 had three new MAC members added.
4 So, I'm going to have to
5 probably find another room for you all when you do
6 come back to in-person that will seat all the MAC
7 members at the table. I don't need to be at the
8 table and we'd have to move the court reporter also
9 and we will wouldn't have enough seating there for
10 everyone.
11 So, I'll have to work on
12 finding us a meeting room large enough.
13 DR. GUPTA: Dr. Partin, may I
14 make a suggestion just because we don't know about
15 the Delta variant and winter is going to be
16 approaching and things like that. Could we just keep
17 it virtual through the January meeting, and, then, at
18 the January meeting, decide how to proceed further?
19 DR. PARTIN: I think that's an
20 excellent idea.
21 DR. GUPTA: Just also with
22 scheduling patients and things like that, it would
23 make it a lot easier to know in advance exactly what
24 we're doing for the next few months.
25 DR. PARTIN: I agree. Does the

1 rest of the Council agree with that?

2 (MAC members in agreement)

3 DR. PARTIN: Okay. So, we will

4 continue with our virtual meetings through this year

5 and, then, at our next meeting in November, we will

6 discuss what we want to do as far as moving into

7 2022.

8 Anything else? Okay. Does

9 somebody want to make a motion to adjourn?

10 MS. EISNER: I make that motion.

11 MS. ROARK: I second it.

12 DR. PARTIN: Thank you, Nina and

13 Peggy. All in favor? So moved. See you all in

14 September.

15 MEETING ADJOURNED

16

17

18

19

20

21

22

23

24

25