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
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DR. PARTIN: We will call the
meeting to order. And for the roll call, Teresa, our
Secretary, was not able to join us today. So,
Sharley, you’ve got your hands full right now but I
don’t have a list of members.

MS. HUGHES: I’ve got it right
here. I’ll do it for you, Dr. Partin.

(ROLL CALL)

MS. HUGHES: I believe you have
enough for a quorum, and, Beth, there’s two more new
members that are to be appointed as of July 1, but I
have not received word from the Governor’s Office
that they have been appointed yet.

So, Barry is representing the
Kentucky Primary Care Association.

MR. MARTIN: Yes. I’m
representing the Primary Care TAC. Glad to be on
board.

MS. HUGHES: Thanks, Barry, and
I’ve got the agenda up now.

DR. PARTIN: Thanks, Sharley.

Next item on the agenda is the election of the Chair,
Vice-Chair and Secretary. Sharley, the only nominees
that I saw were myself for Chair and Dr. Bobrowski
for Vice-Chair and Teresa for Secretary. Do we have
any other nominees?

MS. HUGHES: Yes, but first you
skipped over the approval of the May minutes, unless
you did it and I didn’t hear it.

DR. PARTIN: So, we have
approval of the minutes for the May meeting. Would
somebody like to make a motion to approve the
minutes?

DR. BOBROWSKI: This is Dr.
Bobrowski. So moved.


DR. PARTIN: Any discussion?

All in favor say aye. Any opposed? So moved. Thank
you.

MS. HUGHES: We do have Nina
Eisner has expressed a desire to be for Chair.

DR. PARTIN: I’m sorry, Sharley.

You cut out. I couldn’t hear what you said.

MS. HUGHES: I’m sorry. I’m
trying to do so many things at one time here.

Nina Eisner has expressed an
interest in being the Chair. So, I have created a
poll. Can you all see the poll showing?

(MAC members confirm)

So, only MAC members can vote.
So, if you all will please cast your votes, and this
is anonymous. So, even I can’t see who.

(MAC members vote)

MS. HUGHES: It looks like, Dr. Partin, you will be the Chair.

DR. PARTIN: Thank you, everybody.

MS. HUGHES: So, you can go ahead and continue. If you all want to see them, you can see the results there now.

So, Beth, go forth. I’m going to mute myself and take a couple of deep breaths now.

Have I lost Dr. Partin?

MS. CECIL: No, but, Sharley, if you could go ahead and put the agenda back up, please.

MS. HUGHES: Oh, I’m sorry.

DR. PARTIN: Do we have any - we didn’t have any other nominees for Vice-Chair or Secretary?

MS. HUGHES: No, ma’am. That was it.

DR. PARTIN: Okay. Thank you.

So, then, the Vice-Chair and the Secretary will remain the same.
MS. HUGHES: Yes.

DR. PARTIN: Okay. Thank you.

Now to Old Business. I would like to thank the Commissioner for agreeing to post recordings of TAC and MAC meetings on the DMS website when those meetings are recorded.

I had a number of requests for this and I know people will be happy to have that opportunity if they’re not able to attend the meeting to hear what went on.

We’re going to follow up on the request from the Hospital TAC regarding some IMD’s not being paid by some MCOs as per Managed Medicaid 42 CFR Part 438.

Nina, do you have anything you would like to add to that or any questions?

MS. EISNER: Yes. Thank you. I do. I did have a meeting with DMS leadership on 6/25 and appreciate that for the folks that are in attendance but I still don’t have any further update, and I don’t know if the Commissioner or anyone else does.

DR. PARTIN: So, have you had a resolution to this?

MS. EISNER: No.
DR. PARTIN: Do we need to keep it on the agenda?

MS. EISNER: Yes, please.

MS. PARKER: This is Angie Parker with Medicaid. As Nina had stated, we did meet with her and Matt (inaudible) on June 25th, the Commissioner and the Senior Deputy Commissioner, and we did discuss the issue.

I know that at that point, the Commissioner had talked to the one MCO in particular and they were to follow up. So, my assumption is that that has not occurred.

MS. EISNER: That’s correct, Angie.

MS. PARKER: Okay. I will follow up with that. Anything else to add to that?

MS. EISNER: No. Thank you.

DR. PARTIN: Do we need to keep this on the agenda for the next meeting or are you going to follow up with outside meetings, Nina?

MS. EISNER: I’d rather leave it on until it’s resolved, please.

DR. PARTIN: I’m sorry. I couldn’t hear what you said.

MS. EISNER: I would rather
leave it on, please, until it’s resolved.

DR. PARTIN: Okay.

MS. EISNER: Thank you.

DR. PARTIN: So, we’ll put it on for the next meeting.

Next up, has any work been done to amend the Medicaid regulation to reimburse Certified Professional Midwives?

MS. CECIL: Good morning, Dr. Partin. This is Veronica Cecil with Kentucky Medicaid. And first I want to say I apologize because Commissioner Lee could not be with us today. She certainly tries to always make it to the MAC but she could not be here today. So, we’re going to do our best to fill her shoes by several of us.

With regard to this issue, what our plan is, is this is part of an overall infant and maternal health review that Dr. Theriot, as you know, is moving forward with.

So, we have no plans until we have a more comprehensive plan on what we’re going to do with maternal health to make any changes right now.

So, you’re welcome to keep this on the agenda but our response is going to be that
when Dr. Theriot provides her update in November, at that time, we will certainly share with the MAC what our plans are.

DR. PARTIN: Okay. So, in November, we’ll know what’s going to happen with the CPMs as far as reimbursement?

MS. CECIL: That’s correct, because we, again, are incorporating that in a more comprehensive maternal health initiative.

DR. PARTIN: Okay. I’ll keep it on the agenda just as a reminder to myself to ask about that, but I understand that at our next meeting, there will not be an answer but just to keep it on the plate. Okay?

MS. CECIL: Okay. Sounds good.

Thank you.

DR. PARTIN: Thank you. Okay.

Next on the agenda is to request amendment to the rural health clinic regulation 907 KAR 1:082, Section 1)(b)2, to extend the time to three days for providers to sign Medicaid participant’s chart. Three days would be in line with the regulations and more realistic in a busy clinic setting. Where are we with that?

MS. CECIL: Sure. As
Commissioner Lee had mentioned previously, it is on the list for us to amend. It’s a very long list of regulations that we’ve had to prioritize. So, we do anticipate getting to that. Where it is on the list is probably our goal is around September.

And Jonathan Scott will be providing an update on regulations, the status of regulations on the Commissioner’s update.

DR. PARTIN: Okay. I will keep that on the agenda as well and hopefully we’ll have an answer in September.

And the next item is just a reminder that we’ll have an update on maternal/infant health at the November MAC meeting and I’ll keep that on the agenda as well just as a reminder.

And, then, finally, Judge Phillip Shepherd of Franklin Court ruled in late April that the bidding process which was the second one for awarding the MCO contracts was flawed and must be re-bid. What are the immediate and long-term effects of the Judge’s ruling that the MCO contracts must be re-bid, and how does DMS plan to proceed?

MS. CECIL: So, appeals had to be filed by Friday of last week and there were appeals. So, we are now in that cycle of a continual
court case. And because there is an active lawsuit on this, there’s nothing more we can say right now except that we’re waiting for more court guidance----

DR. PARTIN: So, was it DMS who appealed? I’m sorry. I didn’t mean to interrupt you.

MS. CECIL: No, that’s okay. So, the Finance Cabinet had not filed an original appeal. There were multiple Managed Care Organizations that filed an appeal, but the Cabinet continues to evaluate its legal position.

DR. PARTIN: So, it’s the MCOs who filed the appeal?

MS. CECIL: They did file initial appeals, yes.

DR. PARTIN: Okay. So, I will keep that on the agenda also.

So, in the meantime, what are we following as far as the contracts for the MCOs?

MS. CECIL: The current contracts remain in effect.

DR. PARTIN: Okay. Thank you. And next up is updates. I guess that’s you, Veronica, as well.

MS. CECIL: That is correct.
So, a couple of things that Commissioner Lee definitely wanted us to update you all on.

The first thing is she always likes to provide the enrollment numbers, and our weekly report shows 1,565,664 members. That’s a snapshot, of course, but that’s the snapshot for this week, and 1.3 million of those are in Managed Care.

The next thing is our Senate Bill 50 which is the single Managed Care Organization Pharmacy Benefit Manager implementation that I’m going to shorten to MCO PBM, and we did implement that on July 1st. MedImpact is our single MCO PBM.

I think with any new implementation, you’re always going to have hiccups and we tried to be very candid and transparent that nothing is 100% perfect, but I have to say that from an evaluation perspective, we find that it was very successful.

We believe that MedImpact did just a wonderful job of when issues were identified, addressing them immediately, outreaching to pharmacies, helping to make sure that members are getting the medications that they need.

So, in terms of major systemic issues, we really didn’t see any. That’s not to say
that it was, again, perfect, but there are things that we’re dealing with on kind of a one-to-one basis.

I think it worked the way they anticipated. There’s a lot of transparency with it. We aligned the reimbursement to fee-for-service and the dispense fee to fee-for-service. I think that helped.

I think for the most part, the single PDL helped. There’s still, I think, some education going on around what does that mean when a drug is on the PDL and what has to happen and that transition for members, but, again, having one PBM handling that as opposed to six I think has made it easier on the member, on the pharmacy and that certainly was one of the goals. So, I wanted to provide that update.

The other thing is the Commissioner wanted me to provide some updated data on the missed and cancelled appointments’ initiative.

So, since March, we have 6,522 reports by providers, and that’s a unique provider count of 209. So, we had 209 unique providers uploading information into KYHealthNet about missed and cancelled appointments.
The difficulty is that we have some general buckets that a provider can choose. And, so, our top two buckets are Unknown and Other; but behind that, for cancelled appointments, the next reason was for just an unforeseen issue; and for missed appointments, it was forgot about appointment.

So, again, I think this is helpful for the Department and being shared with the Managed Care Organizations on how do we ensure that members are getting to appointments for the care that they need.

DR. BOBROWSKI: This is Dr. Bobrowski. May I make a comment?

MS. CECIL: Of course.

DR. BOBROWSKI: In the dental arena, these failed and missed appointments is a huge factor. And I know going to the dentist isn’t a lot of fun. It’s not as fun as I told a guy yesterday of going fishing or playing with grandchildren.

We set up times for people to come in, as you all do, and, then, we’ll make appropriate referrals sometimes to oral surgeons. And the oral surgeons around here and across the state, a lot of them are booked out until October and November. And, then folks will have appointments
that we try to get them in pretty quick for surgical
extractions and they just don’t even show up at the
specialist’s office.

And we tell them, you’ve got to
keep these appointments or you may not be able to get
back in at that oral surgeon’s office.

So, I just wanted to give
everybody a shout-out that in the dental arena, it’s
a big problem but that’s all I’ve got to say. Thank
you.

MS. CECIL: Thank you.
DR. PARTIN: Veronica, did you
see that question from Emily Beauregard about
transportation, if transportation is an issue?

MS. CECIL: Transportation is on
the list and it is - for cancelled appointments, it’s
about the fourth down on the list. For missed
appointments, it’s also about fourth on the list but
pretty far behind those others.

And, again, it’s unfortunate
that they’re getting bucketed into Unknown or Other
because that doesn’t give us a lot of information,
and those are by far the largest buckets that
providers are indicating.

And I get it because sometimes
the provider may not know, and, so, they want to
report the appointment being missed or cancelled
which, again, is good information for us, but being
able to distill it down to exact reasons is always
going to be more helpful.

I will say, Dr. Bobrowski, we
have some dentists on the list but they’re pretty far
down. Our largest reporting is in behavioral health
and in primary care. By far, those two are our
largest reporting.

DR. BOBROWSKI: At our office
here, we did a report of all the missed appointments,
and you know how it goes in cycles. Some days you
might have one or two, but, then, I think it was last
Wednesday, I had eight to just not even show up.

I hate to be hard on it but a
lot of offices, you miss one or two appointments and
you’re just dismissed. And I hate it for the people,
but, at the same time, it’s, like, they’ve got to
learn to get with the program and especially when
they’re missing their specialists’ appointments that
we send them to.

I was one of the new providers,
I guess. We did it for about a month, and the other
thing is, like, a lot of offices, they’re so busy
trying to still get caught up from COVID, that some
of them are just saying, well, I just don’t have time
to do one more thing for Medicaid in terms of having
their staff file that report. Even though it’s not a
lengthy process, it’s just one more thing to do.

So, it’s just a problem. I
don’t know. I wish we could figure out something but
behavioral management is the whole key to all of
this. Thank you.

MS. CECIL: Absolutely. And I
see that request in the Chat and we will certainly
add the link to the information about how to record
those missed appointments.

DR. PARTIN: I’d like to make a
couple of comments and observations.

First of all, in 2009, out of
all Medicaid providers, that’s not a very high number
of provider offices reporting; but on the converse
side of that, over 6,000 reports just from 209
providers is pretty significant.

And, then, the other thing
about the Unknown, what we find at our clinic is that
they don’t show up and we can’t reach them to find
out why they didn’t show up. So, that would go into
the Unknown category and it’s very frustrating.
I think some people use cell phones that they purchase at Walmart and, then, when that phone runs out of minutes, they discard the phone and you can’t even reach the people. So, a lot of issues there that confound this problem, I think.

MS. CECIL: Right. I understand that. So, I’m happy to take any other questions or comments around missed appointments; but if not, we have a couple of other updates we want to provide.

We did set our open enrollment dates. We wanted to share those. It will be October 15th through December 1st.

Now, two other things that we wanted to provide updates on are regulations, and I’m going to turn it over to Jonathan Scott for him to update you on where we are with the regulations, and, then, Pam Smith is going to give an update on the HCBS spending plan for the American Rescue Plan funds.

MR. SCOTT: Good morning, everyone.

MS. HUGHES: Jonathan, before you start, TAC members, could you all please start your video so that you’re visible. Thank you. Sorry, Jonathan.
MR. SCOTT: No problem. Good morning, everyone. I wanted to tell you that we have five regs right now that are filed.

So, the first one is the implementing reg for Senate Bill 50. That reg is 907 KAR 23:020 and we also filed an emergency reg on that. So, it could be our first reg that has the dual public comment hearing possibility where we could have a hearing on it next month and a hearing on the ordinary version of the reg the month after that. So, that’s going on right now.

That reg clarifies dispensing fees, when a dispensing fee is eligible to be reimbursed, just a little bit of a cleanup to let us smoothly implement Senate Bill 50.

We also have a group of two regs that is part of the anesthesiology under medical direction. We have recently riled a Statement of Consideration. We also amended one of the regs after comments.

Those regs are currently scheduled to be heard at the August ARRS meeting, the amended and one of them we didn’t amend, and that’s 907 KAR 3:005, 907 KAR 3:010, Physician Services and Physician Provider Services Reimbursement.
We have also filed 907 KAR 3:060 which is an ambulance provider assessment. We got some comments on that reg. So, we are currently preparing a Statement of Consideration for that that we’ll file by the middle of next month.

And, then, we also have 907 KAR 1:038 that is our hearing program reg. That reg allows for individuals over the age of twenty-one to be seen by an audiologist for evaluation and testing purposes only, and we also, for all recipients, an office visit to a physician is not needed before the referral can be made to an audiologist.

A couple of noteworthy regs that may be filed soon - 907 KAR 1:604 which is our copay reg. We will be amending that to comply with the passage of Senate Bill 55 from this last Session, and, then, 907 KAR 3:170 which is our telehealth reg which we will be amending to comply with the passage of House Bill 140.

That’s all I have, just a light review of some of the regs going on. I’d be happy to answer any questions you may have.

DR. PARTIN: Jonathan, the second reg, was that 703 KAR 3:160?

MR. SCOTT: 907 KAR 3:060 is the
ambulance provider assessment reg.

DR. PARTIN: 907. Okay. And
the first one is 703. Is that right?

MR. SCOTT: No. All of our regs
are 907 and, then, KAR. The pharmacy reg is 23:020
and, then, the anesthesiology under medical direction
regs are 907 KAR 3:005 and, then, the other one is
907 KAR 3:010.

DR. PARTIN: Okay. All right.

MS. EISNER: Could you talk a
little bit about the telehealth regulation amendments
that you’re expecting to make?

MR. SCOTT: So, we will be
looking to comply with House Bill 140. So, I think
you can expect some of the things like the
introduction of remote patient monitoring, the
originating site fee that was required by that bill.

There’s some other
housecleaning where we’re going to be just referring
to some other regulations, some other definitions,
some things like that. Then, there’s just a group of
some policy changes that are still kind of at the
departmental level that we are continuing to discuss
internally. So, there will be more on that in coming
months.
MS. EISNER: Thank you.

MS. CECIL: And, Nina, since you asked the question, and we do want to talk a little bit about telehealth, we have some flexibility right now under the Public Health Emergency, which, by the way, as part of my update, I should have said has been extended for another ninety days. So, we were very pleased to see that the Administration took that step.

As we unwind from those flexibilities, one thing that we’re going to really need to talk to the licensing boards and the professional associations about is when can an out-of-state provider deliver telehealth services to an in-state Kentuckian and how do we monitor that and track that within our system because right now some of the licensing boards aren’t allowing that but we kind of have to see what happens as we move out of the current Public Health Emergency, and, then, understanding, because every licensing board is different, are we accurately capturing that because we certainly don’t want to cover a service that’s not appropriate.

So, if you all could be thinking about that. We have a plan to try to reach
out to the different professional licensing boards
and get them involved in that conversation because
communication will be key, especially from the
perspective that we need to know what those boards
and agencies are going to do in the future around
delivering that service.

Thank you for that reg update,
Jonathan. And if there aren’t any other questions
about regulations, I will turn it over to Pam to give
an update on the American Rescue Plan HCB funds.

MR. MARTIN: Veronica, this is
Barry. Has there been thought about with the
telehealth regulations maybe requiring an on-site
visit, an in-person visit every third visit or fourth
visit because that, then, would help the out-of-state
providers to have some kind of connection with the
patient because I’m also afraid that not having that
on-site or hands-on visit is going to cause a lot of
issues and also compromise care in the long run.

MS. CECIL: So, that’s some of
the issues we’re getting into is what should we
require.

And the other thing we wanted
to make very clear is that we’re not necessarily the
arbiter on what should be face-to-face and in
person, I mean, what should be face-to-face and
telehealth. It’s really the professional standards
because we knew when we went to telehealth quickly in
March of last year that there were some licensing
boards and professional standards that had to be
changed because they had required the service to be
face-to-face.

And, so, what we want to make
sure is what is appropriate and, so, we’re having
those conversations.

DR. PARTIN: Veronica, in
regards to the emergency orders, since the federal
order was extended for ninety days, does that mean
all of the current state emergency orders will remain
in place for ninety days?

MS. CECIL: So, there is
definitely a difference between the Public Health
Emergency and the state emergency and I don’t have –
I apologize – all of the information around the state
emergency order; but what I can tell you from a
Medicaid perspective, all of the flexibilities that
we implemented were tied to the Public Health
Emergency.

So, in terms of what might be
happening at the state level, the Medicaid
flexibilities remain in place.

DR. PARTIN: Thank you.

MS. CECIL: If there aren’t any other questions around that, I’ll turn it over to Pam.

MS. SMITH: Thank you. So, we submitted our initial spending plan and our initial narrative to CMS on July 12th. We had applied for and received approval for the initial extension as they were due originally in June; but as most other states did, we received approval for that extension.

And CMS has promised as quick of a turnaround on those as possible. Those initial narratives and spending plans were at a very high level; but to give you an idea of the priorities that we looked at, we wanted to invest in provider and workforce development, service access, crisis services, technology and transformation, and, then, also have a component of project management and administrative support as there is a significant amount of reporting that we have to do to CMS as we go through this process. There are quarterly reports due where at each time we will actually refine spending plans and give updates on the work that we’re doing.
So, for workforce and provider development, we wanted to focus on, number one, trying to help stabilize the workforce, so, looking at can we create some funds for some bonuses or for some immediate money to infuse into the providers to help stabilize the workforce, as well as looking at longer-term solutions on how can we grow the workforce, what can we do as far as training, what can we do as far as recruitment to help providers.

We have heard that they may have individuals that apply for jobs but they don’t show up to the interview. So, how can we work with the providers to help with that?

Is it possible to develop a tract even within the high school system and the vocational programs that’s similar to the CNA tract but that really focuses on the direct support professional. That job is a little bit different in that you really are very engaged in the individual that you’re caring for and advancing what their goals are and their community integration.

Looking at technology solutions. Can we help develop a registry that would help for recruitment, and that also is on the Participant-Directed Services’ side. So, it would
have one central point that if you’re looking to hire
an employee, that you could come and review basically
on a registry individuals that have already had their
preemployment screenings done and that they are
looking for a job in this field to try to shorten the
time that it takes.

Advancing our training.
Training is always important. We’re learning
continuously. So, how can we advance our training?

We wanted to look at easing the
access to HCB. So, how can we strengthen our no-
wrong-door approach so that when individuals come in
and they apply for Medicaid or they come in seeking
some type of benefit, how do we screen them to make
sure that they need maybe assistance with utilities?

And while that’s not something
Medicaid pays for, how can we connect them to the
social resources that will help that? How can we
potentially delay the need for those more in-depth
services or those skilled services? How can we help
them where they are and to continue to help them to
age in place, so, really looking at taking a holistic
view of the individuals.

We also are wanting to look at
our wait list. What can we do for the wait list? We
have a significant wait list for Michelle P. How can we get the individuals that are on that wait list, are there services that we can connect them with right now that either will meet their needs or that will take care of any imminent needs until they have a spot?

We want to go back and look at our rates and our current service menu. We know that rates are an issue. We have begun the rate study. With part of the waiver redesign efforts, we want to go back and revisit that and really see what can we do to make sure that there’s, number one, quality among the rates and that the rates are high enough that we can keep employees and we’re not frankly losing employees to McDonald’s or to Amazon.

We also want to look at our crisis services. So, how can we support the acute and transition services, some of the mobile-based crisis services, the 988 crisis response line, so, working with Behavioral Health to support that initiative and how we can help that.

We also want to do a couple of feasibility studies to look at what will it take and can we implement an SMI and an SED waiver, also looking at chronic disease management and a waiver
that would support children.

    So, with those funds, we are hoping that we can do those feasibility studies to find out what services would be best, what type of funds we would need to allow us to be able to offer those funds.

    So, we’re hoping to hear back within a couple of weeks back from CMS; but in the meantime, we are developing an overall project plan, looking at what the next step will be immediately as soon as we hear back from CMS.

    Stakeholder engagement will be a very important piece that will be strong throughout whatever projects that we do implement.

    So, once we have our approval from CMS, we will begin scheduling some of those sessions with stakeholders. It will include providers and advocates, as well as individuals receiving services or individuals on wait lists and the people that support them to really get their feedback and to engage them to be with us throughout this whole process.

    So, I’ll take any questions if anybody has any questions.

    DR. PARTIN: Pam, would it be
possible for you to share your document with the MAC or even put it out publicly?

MS. SMITH: I can. Yes. I can send it to Sharley to share. We are going to put it on the website. We just had not got that far yet but absolutely I can share the plan that we submitted.

DR. PARTIN: Great. Thank you.

MS. CECIL: And those are the updates that we had planned to share today. I’m happy to take any questions.

DR. HANNA: Veronica, I don’t have a question. This is Kathy. I just wanted to reiterate that the overall transition to the single PBM, MedImpact, has gone very well, as well as could be expected based upon what we had to do, right?

So, a few hiccups but everybody is working through it real well and I just wanted to thank the Department for Medicaid Services and also MedImpact for all of their efforts at making this go forward. Thank you.

MS. CECIL; Thank you so much for sharing that. It is always good to hear good news.

DR. PARTIN: Okay. If there’s no other questions, then, we will move on. Thank you
for all of that information. We appreciate it.

MS. CECIL: You’re welcome.

DR. PARTIN: So, next up are reports from the TACs and recommendations, and we will start with Behavioral Health.

DR. SCHUSTER: Good morning.

Sheila Schuster, Chair of the Behavioral Health TAC.

We met on July 7th and we have a new voting member per House Bill 53, Diane Schirmer representing the Brain Injury Association of America – Kentucky Chapter.

So, all seven of our voting TAC members were there. We also had representatives from Medicaid and from Behavioral Health and a big number of people from the behavioral health community.

I think I mentioned at our last report that we are working very closely with Commissioner Lee and with the data people at DMS to pull data on targeted case management and the first phase of that has been completed by the data folks.

We’re focusing on adults with severe mental illness which is a group that I’ve probably spoken to the MAC about more often than anything, and they’ve identified slightly over 8,600 people that would fit our criteria of people with an
SMI diagnosis who have received targeted case management in a six-month period. So, we’re very excited to actually have some data to look at what the effects of targeted case management are.

We were very pleased to have Dr. Fatima Ali on from the Pharmacy Department and we talked through the transitions, a few hiccups still on the single Formulary but certainly not what we had been experiencing before.

And apparently the transition to the new PBM has gone well, so, I appreciate that and appreciate Deputy Commissioner Veronica Cecil for kind of being a liaison there. We appreciated Dr. Ali being on.

We did have one issue around lockouts for a particular pharmacy or a provider. We had a psychiatrist who is out in the community who had some folks that were in Medication-Assisted Treatment in an agency but the prescriber changed and they got locked out because the prescriber changed. And, so, Dr. Ali was very helpful, I think, in giving him some solutions for that.

We continue to have a big problem and this is not, I’m sure, just in behavioral health but it’s around dual eligibles. So, those
people who have both Medicaid and Medicare or who have Medicaid and some private insurer.

And we had several DMS staff members that were there that were very helpful to us, Angie Parker and Lee Guice, and I think we’re making some headway on this, but we’re going to come back to it at our next meeting just to be sure.

For a long time, people who had two payer sources, we had more trouble getting payment if they had two payer sources than if they only had one which really makes no sense.

I want to talk a minute or two about the no-show or the missed appointments because we’ve raised some issues of concern. We don’t want Medicaid recipients, particularly those with behavioral health diagnoses, to get labeled somehow as bad clients or chronic no-shows and so forth.

So, we were asking some questions about how that data was reported to the MCOs, how frequently it was being gathered and what format it was being reported, and we’re going to get a report back in September.

We also had heard from a number of providers that it was kind of clunky or not a smooth and quick process sometimes to enter the data.
So, we’ve asked them to look at that as well. We’re always checking on the SUD waiver for persons who are incarcerated. And, unfortunately, there’s been no change because of the slowness with which CMS in D.C. is getting new staff on board.

There is a House Joint Resolution 57 Task Force that’s meeting for those of you who are interested in what we call the benefits cliff, people that fall off coverage without having any way of being covered until they get another plan, and we’re very pleased that the Cabinet has pulled together a workforce to look at that.

There are several interim committees that are of interest to behavioral health. There’s one on individuals with severe mental illness. There also is the 1915(c) Home- and Community-Based Task Force that has been meeting. So, we’re very pleased about that.

And we were very pleased that the ABI folks were able to sit down with leadership at Medicaid and at the Department for Aging and Independent Living and come up with some next steps on implementing some of their recommendations. You all will remember that we submitted those to the MAC
last meeting time.

So, we have no recommendations

and our next meeting will be September 1st, and we do

appreciate having this format for talking about

behavioral health. Thank you.

DR. PARTIN: Thank you, Sheila.

Next up is Children’s Health.

MS. HUGHES: Beth, I’m sorry.

They did not meet.

DR. PARTIN: Okay. Thank you.

Consumer Rights and Client Needs.

MS. BEAUREGARD: Good morning.

Emily Beauregard. I’m the Director of Kentucky Voices

for Health.

We met on June 15th and we met

remotely using Zoom. We had a quorum present.

First, I just want to say thank

you to Dr. Partin and other TAC members for making

the recommendation during May’s MAC meeting to share

publicly the video recordings of MAC and TAC meetings

when they are recorded.

I also want to thank

Commissioner Lee for accepting that recommendation.

I think this is a really great opportunity to make

MAC and TAC meetings more accessible not only to
members who may miss the meeting for one reason or
another but also for Medicaid members and for the
general public who may have a conflict during that
time and need to catch up on that later.

So, I’ve heard that if we go to
some sort of hybrid schedule where some of us meet in
person, others might want to meet remotely but there
may not be the equipment right now to support that,
but I do hope that DMS will be able to invest in some
equipment so that we can have those hybrid meetings
and still have that remote option and can be recorded
because I really think that it’s just a great
opportunity for more accessibility and transparency,
and I think it’s worked really well for us to have
that additional option.

So, during our June meeting, we
discussed a number of our usual issues that we’ve
presented to you before - presumptive eligibility,
coverage options for immigrants, updates on our
1915(c)waiver programs, SUD services and reentry
supports.

We also discussed the rollout
of the new single Pharmacy Benefit Manager, the PBM,
as well as opportunities to expand postpartum
coverage and the Home- and Community-based Services
that have been made possible through the American Rescue Plan Act.

So, we were really glad to learn more about the work that DMS is doing to improve child and maternal health through the Perinatal Quality Collaborative. I think that’s very valuable.

In particular, we were excited that DMS is seriously exploring the option to submit a State Plan Amendment to extend postpartum coverage from what is currently two months postpart to twelve months. This is particularly important for moms with incomes that are just above the 138% of the Federal Poverty Level.

That’s the typical cap on enrollment or on eligibility, and it’s one of the many ways that we can begin to address health disparities that have been caused by systemic racism. So, we very much support that and hope that it moves forward.

After years of discussing barriers to healthy reentry, we really appreciate that DMS has created a new MAP form that people who are no longer incarcerated can use to lift their suspension status and activate their Medicaid
coverage.

This has been an issue I guess for years where people are released from incarceration but their Medicaid stays in a suspended status which means that they can’t get the coverage or the services that they need to support perhaps their recovery and just generally their health.

So, this is particularly important, of course, for people who need access to behavioral health and SUD treatment.

Now, this form isn’t necessary for every person who leaves incarceration. Some people, their suspension gets lifted in the way that it should initially; but for those who, the date isn’t updated in the system in a timely fashion or something gets entered incorrectly, this form gives the individual or their authorized representative the ability to fix that problem.

We’re not sure yet how well it’s working but we’re monitoring this closely, talking to community health workers and Connectors and trying to make sure that people are aware of the form.

And, finally, we discussed the rollout of the single PBM. We’re really happy to
hear that so far things have been going well and we
certainly haven’t been hearing of issues that people
have experienced yet.

I think the targeted outreach
that DMS has planned for members and just the
planning that has been done in advance of the rollout
has probably made it much smoother than it could have
gone. And, so, we appreciate all of the work that’s
gone into that.

I do think that because we’re
in this grandfather period of people having ninety
days essentially since July 1st for prescriptions
that have been grandfathered in that may no longer be
on the Preferred Drug List, right now we’re probably
not seeing some of the issues that we may see at the
end of that period which I think would be at the end
of September.

So, we’re going to be
monitoring that as well. I just want to make sure
that every Medicaid member knows that there could be
some changes coming to that Preferred Drug List and
that there may be some prior authorizations required
for things that didn’t require a PA in the past. So,
just important information for providers to be
sharing with their patients as well.
We had one recommendation from our June meeting which was that DMS customize a PBM letter targeted to impacted Medicaid beneficiaries that includes the names of medications that will now require a prior authorization.

DMS already had a letter planned but not with information about specific drugs. So, we thought including that specific information would be helpful to the member.

And, then, our next meeting date is going to be August 17th at 1:30 and we’ll have new members joining us at that time and that’s all I have. Thank you.

DR. PARTIN: Thank you, Emily.

Dental TAC.

DR. BOBROWSKI: Yes. This is Dr. Bobrowski. Our next meeting is August 13th.

I know that we brought up in the past the issue of a soda tax, and the KDA has had numerous meetings on this and we have an Executive Board meeting this Saturday and this topic will be brought back up again.

So, other information will come forward on that and there’s pros and cons on anything like that, especially when you’re trying to maybe
change behavior but at the same time it is a tax and we would all have to pay it.

A lot of discussion this morning has been on these prescriptions and stuff, and Kentucky is not too bad just yet, but I know one thing to kind of keep on our radar is the State of Pennsylvania, it costs dentists right at $3,000 a year just to be able to do their electronic prescriptions.

So, please, let’s all work together. Don’t let that happen in Kentucky. There is a fee for us to do that but it’s nowhere near that.

And I did have one question for Dr. Schuster. I was going to ask you about what you felt like your outcome was when you had your meeting with the Medicaid Oversight and Advisory Committee, if that’s okay to ask on a TAC report?

DR. SCHUSTER: I testified about the suspension of prior authorizations for behavioral health and there was no action taken because they’re in the Interim Session, Dr. Bobrowski, so, they can’t do anything, but certainly the comments from I think almost every one of the members of what we call the MOAC, the Medicaid Oversight and Advisory Committee,
was very positive about maintaining those suspensions.

The recommendation I made was that they be maintained at least until the end of the year when we’re kind of out of the COVID impact hopefully and we have some more of this data that we’re collecting. So, thank you for asking.

DR. BOBROWSKI: That is all the Dental TAC has to report for today. Thank you all.

DR. PARTIN: Thank you. Nursing Home.

DR. MULLER: It’s John Muller. Our TAC Chairman, Terry Skaggs, had an unexpected emergency. So, I’m the MAC member but I’d like to at least read this in for Terry.

The Nursing Home TAC met on Wednesday, June 30th, attended by most of the TAC members. Agenda items discussed included whether or not future meetings are virtual versus the in-person and we will keep going forward with the virtual format.

The Department for Medicaid provided an update on the funds paid to date for the $270 COVID add-on per day and the additional bed reserve payments that were part of the COVID
emergency.

TAC members were also able to confirm the normal rate inflationary adjustments that will be made to the price of 1.09% and 2.5% for the capital and the non-capital components respectively effective July 1st, ’21.

TAC members also discussed the efforts made by the Association to affect changes to Medicaid eligibility, the policy to more closely align with the way other states grant Medicaid eligibility for long-term care. DMS agreed to review the documents provided by the TAC and have responded to the Association and we are going to work together to adopt the policies where practicable.

We also discussed the new hybrid, very important to us, level-of-care process that would include obtaining a sample of residents and, then, a 90% or more accuracy threshold, and if we pass the threshold, level-of-care testing would only occur once per year.

After discussion, the TAC had several questions regarding this new Carewise level-of-care implementation including what action is going to occur if the facility does not meet the 90% accuracy of the sample. Will the facility be
provided a list of the sample residents prior to the onsite review?

And as of the initial approval, after review of the KLOCS' information, we only have a 30-day window. If reviews are only going to be yearly, we need it clarified, how will the extension process work if it’s several months between the required assessment of the KLOC and, then, the yearly review?

DMS answered the questions during the TAC but we are going to need further followup at our next TAC meeting from DMS on those.

And, lastly, we had a discussion of the MAP-350 provider letter implementation. We greatly appreciate the Department’s removal of the requirement to obtain signed and dated signatures annually and also had a discussion of what’s going to happen to Medicaid recertifications once the PHE ends if we, as noted earlier, have a bit more time with the extension signed earlier this week.

That concludes Chairman Skaggs’ report from the Nursing Home TAC. Thank you.

DR. PARTIN: Thank you. Home Health.
MS. HUGHES: The Home Health TAC did not meet, Dr. Partin.

DR. PARTIN: Okay. Thank you.

MR. RANALLO: This is Russ Ranallo, Chair of the Hospital TAC.

The Hospital TAC met on June 22nd. We had a quorum. We don’t have any recommendations.

Some of the items that we talked about, we talked about the WellCare short stay policy. WellCare put out a policy that was approved by DMS that basically said, outside of a few exceptions, anytime a patient came into the hospital and had any stay less than two days, they were to be considered observation regardless of whether they met the medical necessity criteria to be an inpatient.

Numerous hospitals, once they saw the policy, had issues and questions. For example, it wasn’t clear what populations the policy applied to. OB and newborn very often have a stay of two days or less and would they be observation and not inpatients?

The policy was rescinded, sent back to WellCare. WellCare revised the policy and
sent it back to DMS and we raised concerns that the policy was against information in the regulation but also maybe in the contract between WellCare and the State.

The Hospital Association had a meeting after the TAC meeting with DMS and went over our concerns. The policy is still in draft form, as I understand it.

We talked about the WellCare NICU policy, another policy where WellCare would reduce outlier payments when the hospital billed a level of care that did not match the level of care authorized or approved by the WellCare vendor, Progeny.

We talked about the administrative burden and the reduction of payments and that no other MCO or really any other insurance plan has this type of policy for an inpatient baby.

The psych hospital EMTALA requirements, you heard that earlier in the meeting. The other items, we agreed to continue to Zoom meet for the remainder of the year and, then, Bud Gorman with KHA talked about the KHA Patient Transport Committee.

Large parts of the hospitals
are reporting having issues with non-emergent transport and getting patients to the proper level of care resulting in delays of care on occasions and also using transports that are more expensive, whether it’s fixed wing or helicopter.

The next Hospital TAC meeting will be August 24th. Thank you.


MS. HUGHES: They did meet but there were no recommendations. I haven’t seen anybody on here to tell you that.

DR. PARTIN: Okay. Thank you.

Nursing TAC.

MS. HUGHES: They did meet last month. It was more of an organizational meeting and appointing the Chair and so forth. So, they didn’t have any actual report to make today.

DR. PARTIN: Thank you.

Optometry.

DR. COMPTON: Steve Compton. We have not met since the last MAC meeting. We’re scheduled to meet again on August 5th. So, we have no report.

DR. PARTIN: Thank you.
Pharmacy.

MS. HUGHES: Pharmacy did not meet either.


DR. McINTYRE: This is Dr. William McIntyre. I’m Vice-Chair of the Physician TAC.

We met six days ago, July 16th. We had a number of discussions. We’re going to have in-person meetings every third meeting. So, the next in-person meeting that we’ll have will be in November.

We discussed the soda tax; and while we don’t have a recommendation on that, we want Dr. Bobrowski and his TAC to know that the Physician TAC fully supports using a soda tax to try and influence consumer behavior to reduce the intake of soft drinks.

We do have one recommendation. We discussed Medicaid limits on complex evaluation and management office visits in chronic care management, and there’s a KAR regulation, 907 KAR 3:010(10), and this regulation limits Level 4 and Level 5 office visit reimbursement.
The regulation says that 99214 and 99215 shall be limited to two per recipient per provider per calendar year.

Our concerns are, first of all, the reimbursement for those levels is already well below the reimbursement for the same levels by surrounding states.

And, second, physicians and other providers have to learn the CPT codes, apply them correctly and that’s frustrated by having the CPT codes automatically reduced if it’s been more than two visits in that calendar year that have had those higher levels.

Also, a lot of our patients are elderly. Their care is complex and having the limits on the codes that are used, the code for those complex visits defeats the purpose of having those codes in the first place.

And, third, with the limited reimbursement for those codes and with the limitation on only having two of those high Level 4 and Level 5 visits a year, this interferes with the efforts to recruit physicians to come in to the state.

So, our recommendation is that the limits to two Level 4 and Level 5 visits a year
per recipient, that that be eliminated and that sums
up our meeting and our recommendations.

DR. PARTIN: Okay. Thank you.

Next up is Podiatry.

MS. HUGHES: They did not meet.

DR. PARTIN: Okay. Primary Care.

MR. MARTIN: This is Barry Martin. I’m a member of the Primary Care TAC, and our Chair, Mike Caudill, was unable to participate in the MAC call. So, I will give the report.

We met on July 1st and we did not have any recommendations. However, we did discuss having a hybrid meeting for our next meeting where we would have the option to meet in Frankfort at the Kentucky Primary Care Association office for the TAC members or have it via Zoom and, then, we would meet via Zoom with the DMS members for our next meeting which is September 2nd, and that’s all I have to report.

DR. PARTIN: Okay. Thank you.

And last, Therapy Services.

MS. HUGHES: They did meet but it doesn’t appear that there’s anyone here from that TAC but there were no recommendations.
DR. PARTIN: All right. There were none?

MS. HUGHES: There were none, no, ma’am.

DR. PARTIN: Okay. Thank you. So, that concludes the reports and recommendations for the TACs. Would somebody like to make a motion to accept the recommendations?

DR. GUPTA: I move. Dr. Gupta.

MR. WRIGHT: Second. Eric Wright.

DR. PARTIN: Any discussion? All in favor, say aye. Any opposed? Okay. The recommendations are accepted.

Then we move on to New Business. Before we do New Business, Deputy Commissioner Cecil had something else she wanted to report to us.

MS. CECIL: Thank you, Dr. Partin. I can’t believe I forgot to mention this, especially with the discussion around Senate Bill 50, but I did want to announce that Dr. Fatima Ali who has been serving as an Associate Pharmacy Director has been essentially named our Acting Pharmacy
Director.

And I can assure you that the success of Senate Bill 50 is due to her hard work. I really can’t take any credit. She was just amazing and phenomenal and made sure that things went smoothly.

So, I just wanted to announce to everybody that Dr. Ali will be stepping in as Acting Pharmacy Director, and we do plan to hire two Clinical Managers that will help us manage both the Managed Care side and the fee-for-service side.

Thank you.

DR. PARTIN: Thank you. To New Business, I have two items under New Business.

One, I was wondering if DMS can tell us, of course, not today, but give us some idea about the COVID vaccination rate for Medicaid recipients. Would that be possible?

MS. CECIL: Absolutely. We are tracking it and, you’re correct, I don’t have it at the top of my head right now but we are absolutely tracking it. I’ll be more than happy to provide that.

DR. PARTIN: Okay. So, I’ll put that on for the next meeting.
And, then, the next item for New Business is to discuss whether we want to continue the Zoom meetings or in-person meetings or some kind of mixture of that.

I would like to recommend at least for our next meeting that we continue with Zoom just because of the Delta variant surging right now, but I’m open to any discussion or comments on that.

MR. ESSEK: If I may. I’d like to see at least a hybrid type of meeting.

DR. PARTIN: I couldn’t hear you. I heard that you said some kind of hybrid.

MR. ESSEK: Yes, ma’am. Daniel Essek, Peer Support. I would like to see some type of hybrid meeting where even if it’s in-person, that there be a Zoom component of it.

DR. PARTIN: Is that possible, Deputy Commissioner?

MS. CECIL: We’ve expressed this with each of the TACs that we are concerned about the availability of meeting rooms that can accommodate both an in-person and a virtual.

Part of that is because, as you noted with the variant, we remain concerned about having the availability for as many people that want
to attend in person and ensuring the safety.

So, we’re certainly leaving it up to you all to make the decision on what you want to do and we’ll work towards that. We do need, I think, some time to figure that out if we wanted to move to a hybrid, and I do recommend a hybrid because, as you can see with the number of attendees we have today, this has certainly opened up the ability for more participation which is wonderful.

So, if we wanted to move to hybrid, I’m not sure if we could do it by the next meeting but certainly we’d be happy to work towards that.

DR. PARTIN: Okay. So, as far as the MAC goes, for our next meeting, are you all in agreement that we meet virtually for our next meeting?

(TAC members in agreement)

DR. PARTIN: Okay. And, so, we can discuss that further, then, at our next meeting in September of how we want to proceed. Does that sound okay to you all?

(TAC members in agreement)

MS. HUGHES: Dr. Partin, one other thing, too, is that the meeting room that you -55-
all were using, if all the MAC members attended, was
crowded to get you all all at the table and you’ve
had three new MAC members added.

So, I’m going to have to
probably find another room for you all when you do
come back to in-person that will seat all the MAC
members at the table. I don’t need to be at the
table and we’d have to move the court reporter also
and we will wouldn’t have enough seating there for
everyone.

So, I’ll have to work on
finding us a meeting room large enough.

DR. GUPTA: Dr. Partin, may I
make a suggestion just because we don’t know about
the Delta variant and winter is going to be
approaching and things like that. Could we just keep
it virtual through the January meeting, and, then, at
the January meeting, decide how to proceed further?

DR. PARTIN: I think that’s an
excellent idea.

DR. GUPTA: Just also with
scheduling patients and things like that, it would
make it a lot easier to know in advance exactly what
we’re doing for the next few months.

DR. PARTIN: I agree. Does the
rest of the Council agree with that?

(MAC members in agreement)

DR. PARTIN: Okay. So, we will continue with our virtual meetings through this year and, then, at our next meeting in November, we will discuss what we want to do as far as moving into 2022.

Anything else? Okay. Does somebody want to make a motion to adjourn?

MS. EISNER: I make that motion.

MS. ROARK: I second it.

DR. PARTIN: Thank you, Nina and Peggy. All in favor? So moved. See you all in September.

MEETING ADJOURNED