CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

January 23, 2020
10:00 A.M.
Transportation Cabinet
Auditorium
Frankfort, Kentucky

MEETING

APPEARANCES

Elizabeth Partin
CHAIR

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

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AGENDA

DR. PARTIN: Good morning, everyone. Can everybody hear me okay because we don't have microphones up here?

So, the first order of business is the roll call. Teresa.

(ROLL CALL)

MS. ALDRIDGE: We do have a quorum.

DR. PARTIN: Next up, we'd like to welcome Commissioner Lee back. It's a pleasure to have you.

COMMISSIONER LEE: It's very good to be back. Should I move to the table?

DR. PARTIN: Sure.

COMMISSIONER LEE: So, it's good to be back and I think, just for those of you who may not know me - I see some familiar faces - some maybe not so familiar - I'm Lisa Lee.

I am a previous Medicaid employee. I worked in Medicaid for sixteen years before retiring. During those sixteen years, I served in a variety of roles.

I was a Member Service Representative, a Provider Service Representative. I also served as a Policy Analyst, Deputy Commissioner,

Commissioner, and I also served as the CHIP Director for fourteen years.

So, I have a little bit of knowledge about the Medicaid Program and some of the workings and the relationships of all the other programs.

So, I'm very glad to be back and look forward to working with you to move this program forward in a manner that benefits all of Kentucky.

DR. PARTIN: Thank you. Next up is approval of the minutes from November. Would anyone like to make a motion?

MR. CARLE: I'll move.

MR. TRUMBO: Second.

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

We have two of our members who have just come in. Teresa, do you want to add them?

MS. ALDRIDGE: Dr. Spivey is present and also Ann Morgan has come in.

DR. PARTIN: Thank you. Under Old Business, first up is MCO contracts. Commissioner.

COMMISSIONER LEE: So, we do have an active procurement, so, we are not going to be able to discuss anything related to that. Responses are due February 7th. So, we're still operating under the current MCO contracts.

DR. PARTIN: Did you say February 7th?

COMMISSIONER LEE: February 7th is when they are due, the responses will be due.

MR. CARLE: And what's the time frame for those after they're accepted when they will come in place and be active?

COMMISSIONER LEE: After we receive all responses, we will, of course, have to do the review and that could take up to a month. Do we have a timeline, Stephanie?

MS. BATES: So, as far as the timeline for the procurement, it's kind of fluid. It will probably take, just like any other big procurement, it could take up to a couple of months, but the actual contracts that will be awarded will be effective starting 1/1 of '21.

MR. CARLE: Okay, 1/1 of '21.

MS. BATES: Yes, so, it aligns more with the benefit year.

DR. PARTIN: At the last meeting, we talked about work being done on the medication formularies across all the MCOs to make the formularies consistent. So, where are we with that?

COMMISSIONER LEE: Well, currently, the RFP that was released, if you go out and you look at the model contract that is attached to the RFP, we do have language in there giving the Department the option to move to a single formulary.

A lot of things are unknown at this time. We know, for example, that there could be potential legislation with a Medicaid pharmacy carve-out from the MCOs. If that happens, this may not be an issue.

So, a lot of unknowns right now, but we do have the information in the model contract giving the Department the option to move to a single formulary if we decide that that's in the best interest of the members and the program.

DR. PARTIN: Okay. So, if the legislation doesn't move forward carving that out, do you think that's something that's going to be part of the discussions with the MCOs?

COMMISSIONER LEE: It's

something that we can definitely explore, yes.

MS. CURRANS: But it would not happen until 1/1 with the new award.

COMMISSIONER LEE: Well, yes. The new award would be 1/1, but the pharmacy carve-out, we're not sure right now if those negotiations would take place after the award of the contract or before because I think there's still a lot of unknowns out there that we would have to look at and research just to make sure that we move in the right direction.

DR. ROBERTS: Would the pharmacy carve-out be allowed with a change in departmental policy or would it require a legislative act?

MS. BATES: It would not require a legislation action.

COMMISSIONER LEE: That's why the model contract, again, that's attached to the RFP has language giving the Department that option to move forward.

DR. PARTIN: So, what are some of the things that are drawbacks that would be preventing the Department from moving in that direction?

COMMISSIONER LEE: I'm not sure

at this time. This is Day 5 on the job. I do know that this has been an issue even before I left. We just definitely would have to look at the same things we look at with any policy change.

So, we have to ask ourselves certain questions. How is it going to impact the member? How will it impact the provider, our system changes and most of all our budget?

So, those are questions that we would definitely explore and look at and we would look at other states that maybe have a single PDL in place so that we could look and see if there are any issues, pros, cons to what happened when they moved in that direction.

So, again, it's not something that we want to rush into. It's something we want to actually think out and do a methodical process to have as little disruption if possible in the event that we moved in that direction.

DR. PARTIN: Thank you. Okay. Next up, at the last meeting, we discussed how the dentists were able to use a code for no shows, and the question was could other providers also use that code.

COMMISSIONER LEE: I think we've

done a little bit of research. I mean, there's no CPT code for a no show and I'm not sure that a dental code could be put on a CMS 1500 now. I'm not sure how we could do that.

MS. BATES: So, there is a dental code, a "D" code for that, and as you all know, that's kind of where this conversation started, but we haven't been able to find through any of the coding, HCPCS or CPT. As big as the books are, there aren't codes for that specific service for all other providers.

And, so, the whole purpose of the code is obviously to track the no shows and try to outreach. So, it's great that there is a dental code, but providers generally - I'm a certified coder.

So, I do know that providers really drive new codes that come in. So, if your coding people or whoever want to make those recommendations to the folks that actually do the books and do the coding, that would be great because it would be a good way to track no shows but there isn't anything that I've seen yet.

DR. PARTIN: Also, we've talked about this for years and years, but problems related

to the MCOs not requiring participants to see their assigned providers and inappropriate assignments of patients.

Is there any thought about discussing that in the contracts with the MCOs? Passport is the only one who does it.

COMMISSIONER LEE: So, is it two different issues? So, do we have individuals who have an assigned provider on their identification card and they're not going to that provider?

DR. PARTIN: No. The problem is that - yeah, that is part of the problem. There's a bunch of issues with it.

One is is that people are being assigned to providers who are inappropriate for that participant, for instance, adults being assigned to pediatricians or patients getting assigned to physicians who only do hospital work.

And where that becomes a real big issue is that providers are being evaluated based on the quality of care that they are providing. And, so, if you don't see the patient and another provider is seeing them or no provider is seeing them, for instance, in the case of a provider who does exclusively hospital work and participants are

assigned to them, that participant probably isn't seeing that provider ever. Then that provider is graded by the MCOs on different measures.

MS. CURRANS: I thought that provider could notify Lisa and make them aware that they shouldn't be assigned to ambulatory care.

MS. BATES: So, at anytime the providers or the beneficiary can reach out if there's an improper or just incorrect PCP assignment.

The Commissioner and I talked about this yesterday a little bit. The member has to have a choice, but sometimes the choice may not look like it is within the PCP requirements. So, there's all kinds of variables.

We talked about the panels and how providers are graded and there's these incentives that are attached to some of these panels.

DR. PARTIN: The thing is that the participant doesn't care because they go wherever they want to go anyways and the provider doesn't know. You don't know until you get that paper saying you failed on all these measures, and it's like I don't even know who this person is. So, that's when you know and, so, then you've got these bad points against you.

COMMISSIONER LEE: So, when that happens, let's say you're a provider and you have a panel and some of those individuals don't come to your office and, then, you see that it's impacting your quality scores, what are the options for you as far as the MCO? Can you notify----

MS. CURRANS: You can notify and that is what you have to do.

COMMISSIONER LEE: ----the MCO and say I don't have these and kind of have those scores changed and update those scores?

MS. CURRANS: That's what you have to do.

DR. PARTIN: But the other part of it is is if the patient is assigned to you and they're not coming to you, they could go anywhere they want to go. So, again, you're not meeting the quality measures and you have no control over it because the patient is going someplace else.

COMMISSIONER LEE: And I think because of the freedom of choice and for individuals being able to - and that's a CMS rule, that all of our members have to have a freedom of choice of providers. And if your name is on their card and they're not seeing you, I'm not sure if the MCOs can

maybe run some sort of a routine report or something to identify individuals who aren't going to the primary care individuals and maybe reach out to those members before they change their provider or something like that maybe to see----

MS. CURRANS: It's a pain but you can reconcile all of this with the MCO.

MS. BATES: You can. So, if you look at it from the perspective of the MCO, the MCO's job is to ensure that their members get the services, whether or not they get them at the PCP or at another provider.

So, from their perspective, it looks like - because their job, right, is to ensure that everybody gets services and these preventive services. So, if it looks to them as though they did get a PCP-like service but it just so happened to be at a different place, then, from their perspective, they got what they needed.

I understand both sides of it. It's administrative work but it can be done.

MR. TRUMBO: If there's freedom of choice, why even make an assignment?

COMMISSIONER LEE: One of the main reasons to make an assignment is to assure that

individuals do have a PCP that they can go to.

MR. TRUMBO: A default option?

COMMISSIONER LEE: Without an assignment, an individual may have to call several different providers to get access.

DR. PARTIN: For instance, Passport does assign patients, and the patients can sign up when they come to the clinic or the office or they can wait and choose a different MCO during the sign-up time, but it really is a lot of extra work for the clinics to have to do that.

We don't receive lists of which patients are on our panels. We don't know who those people are.

COMMISSIONER LEE: So, is this mainly a Passport issue? I know you've mentioned them twice.

DR. PARTIN: Passport is good. They assign the patients, and, so, you know that those patients will come to you. They can change. Those patients can change their provider. That's not the problem.

For instance, if a patient has Passport and they come to my clinic but they're assigned to somebody else, we can call Passport and

we can get that patient changed. We just hand the patient the phone over the desk and say, here, tell them you want to change to us because you've been coming here and you're not going to this other provider.

That's an easy-enough thing to do but at least we know who the patients are and who is assigned to us, but the other MCOs, they're assigned to various providers. Sometimes the patients don't even pick those providers. They're just auto-assigned.

DR. ROBERTS: The MCO should be able to run a report, and if a covered person is getting more than 50% of their non-specialist visits at another provider, I mean, that should be a clear indication to the MCOs that, okay, either they need to change the provider or something has got to change.

Now, a lot of patients will go to Urgent Care for appropriate, non-emergency room things and I don't want to discourage that because that keeps them out of the Emergency Room.

But, still, I think if you strip out the specialists, if somebody goes to the doctor six times this month and two are to the Urgent

Care and the other four are to a specific provider that they're not assigned to, something has to change.

COMMISSIONER LEE: I think what we can do is circle back with the MCOs and see if they can generate a report that identifies how big of an issue this is, how many individuals are assigned to a certain primary care provider but going to a different one and, then, we can kind of take a look at that and see what we can do moving forward, but I think that's going to have to be our next step in order to kind of get this resolved.

MS. CURRANS: But I do like the freedom because if they can get into an UTC that evening, it's a lot better than coming in to the ER. So, freedom is important.

DR. PARTIN: Advanced Care Planning. And, Chris, you were going to talk about that.

MR. CARLE: Yes. This is something that I spoke to Commissioner Lee and Ms. Bates about. If you don't know what Advanced Care Planning is, it's basically setting up an advanced directive for the patients.

We found in health care that

it's a tremendous cost saver specifically for end-of-life care. And, so, it's something that I think that this committee is interested in working with the team on developing for the patients that are obviously covered by DMS because of the fact that it sets up their wishes in advance.

In the event that there's nobody else there to communicate that or validate it with a legal document, it's something that can end up saving all the health care providers involved quite a bit of money and saving a lot of angst and issues for the family.

So, if you don't know what I'm talking about, there's DNR orders or do not resuscitate when an individual comes in.

Most everybody wants all the heroic measures taken that possibly can happen, but in the event that you have a wish in advance of that, it has to be documented and, therefore, we think it's a good idea that the Department start to promote this through the community that they serve so that we can, again, get these advanced directives out in advance in plenty of time so that it can be communicated when and if this should happen.

So, we will be working together

with them. I know Sheila and all the hospital reps, it's a big part of what we actually do. And, so, we would like to see that kind of carried forward through the rest of the Commonwealth.

DR. PARTIN: Thank you. So, on all these Old Business things, the only one that we will be coming back to is a follow-up on the assignments of patients.

Any updates, Commissioner?

COMMISSIONER LEE: Well, Day 5 being back to work here, I'm really excited to be back and work with you.

I do see that a few little items on here, some of the Old Business are items that were here four years ago. I hope that we can begin to move past some of this Old Business and start really focusing on our members.

My philosophy as a Medicaid Director is the Medicaid Program was created for the Medicaid member. Everyone in this room is here for the same reason and that is to improve the health care status of this state.

And I truly think that we are partners in this and do look forward to working with all of you as we move forward to address some of the

more important issues facing our members. And, hopefully, at the next one, I'll have more of an update on actual progress that we have been doing.

DR. PARTIN: Thank you.

MR. WRIGHT: Can I ask a question? Have you started to consider your team and do you foresee the vision of changes within the hierarchy of the program?

COMMISSIONER LEE: I have a really good team. A lot of them were in place when I resigned or retired four years ago. At this point, I don't have any plans to make big, wide, sweeping changes in the Department.

I think we need as much consistency as we can get. I haven't been very involved in the Kentucky Medicaid Program in the past four years. So, I think that there's some knowledge and historical information that I need to catch up with.

I have been working at the national level a little bit and I do see that we have a lot of the same issues at the national level, but, again, I don't have any major plans to go in and make wide, sweeping changes in the Department.

MR. WRIGHT: And just for my

knowledge, who are the associates that are currently in place? It used to be I believe Jill Hunter.

COMMISSIONER LEE: No. Stephanie Bates is currently a Deputy Commissioner. She is still on the team. Most of our Division Directors are here and we'd be glad to have them introduce themselves if you need to put a face with a name.

MR. WRIGHT: It wouldn't hurt.

MR. BECHTEL: I'm Steve Bechtel. I'm the Chief Financial Officer in Medicaid.

MS. GUICE: Lee Guice, the Director of the Division of Policy and Operations.

MS. PARKER: I'm Angie Parker. I'm the Director of Program Quality and Outcomes.

DR. JOSEPH: I'm Jessin Joseph, Pharmacy Director.

DR. THERIOT: Judy Theriot, Medical Director.

MS. RICHARDSON: Amy Richardson, Director of Fiscal Management.

MS. HUGHES: Sharley Hughes with the Commissioner's Office.

COMMISSIONER LEE: And she coordinates with the MAC meetings. Pam Smith is

currently the Director for the waiver programs, the 1915(c) waiver programs.

MS. BATES: And, then, we have Michelle Rudovich who is Program Integrity Director.

COMMISSIONER LEE: Thank you all.

DR. PARTIN: Thank you. Let's move on to reports from the TACs and we'll start with Therapy.

DR. ENNIS: Good morning. I'm Beth Ennis. I'm still serving as the Chair of the Therapy TAC.

We met on the 14th in person and by video conference. We did have a quorum. We're working through some things.

I think coding and billing schedule and fee schedule still remains a problem and it's not a Cabinet problem. It's whoever the vendor is to load the fee schedule because it is still taking - I mean, we're at the end of the month of January. We've had stuff to them since I think Charles gave it to them in November/December and we still don't have a fee schedule for 2020.

And we've had MCOs who won't back pay because their contract says they don't have

to. So, they have ninety days from when it's finally corrected to pay the providers the fees that are posted.

I'm not sure how we're going to address it. We're trying to work through that but it seems to be a vendor problem and not a Cabinet problem. So, we're doing the best we can with that and Charles is working hard.

The positive thing that came out of our last meeting is that we do have a pilot program that physical therapy is doing with some of the addiction recovery centers working with our folks with the opioid crisis and finding some really good results using physical therapy as an adjunct service in those centers.

The challenge is that PT is not a part of that daily rate. And, so, we were able to approach Stephanie because we didn't have Commissioner Lee in place yet and just ask if they were able to bill PT out of the State Plan separate from that daily rate.

And, so, we're investigating how that will work so that hopefully we can continue to have a bigger impact on that population.

We didn't have any

recommendations for the MAC at this point, continuing to work through issues with various MCOs at that level and generally succeeding with that.

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

MS. HUGHES: They met but did not have any recommendations.

DR. PARTIN: And I got backwards. Sorry about that. Primary Care.

MS. KEYSER: Good morning. I am Chris Keyser. I am the Vice-Chair for the Primary Care TAC. The TAC met on January 2nd of this year. A quorum was met.

I'd like to just give you a short summary of our current agenda items that we're working on. A couple of points focus on billing and coding issues, specifically the UB modifier.

We are awaiting confirmation from DMS that the UB modifier can be appended to any and all codes that groups do not want to be paid the wrap payment for.

This is unique to the rural health clinics and federally qualified health centers who get reimbursed on the prospective payment system and we receive the first half of the payment

fee-for-service from the MCO and, then, DMS makes the wrap payment to make our total payment whole and we are having issues with encounters being paid that do not qualify for being paid. And the only way that DMS can distinguish that is if we use a modifier but we're having problems with the modifier.

Also, additional "G" and "T" codes. A full list of the desired "G" and "T" codes were submitted in December to DMS and it's our understanding that these were placed on the same change order as the UB modifier that I just mentioned earlier and we're still waiting on confirmation from DMS on the completion and the details of when those can be implemented for us.

The agenda item that really took a lot of our time, the committee discussed the 340-B Pharmacy and Procedure Manual that was released. We have some concerns that it did not go through the regulation review process of KRS Chapter 13A.

And, so, we asked the staff from the KPCA to submit arguments on our behalf to DMS as to why the regulation applies.

Then, Commissioner Steckel, we sent that request to her per her request to the

attorneys and, then, we re-sent them to the DMS leadership here in early January because of the transition. So, we're still awaiting the response from Medicaid.

And at this time, the committee has no formal recommendations for the MAC.

DR. PARTIN: Thank you. Podiatry.

MS. HUGHES: They don't meet.

DR. PARTIN: Physician Services.

DR. McINTYRE: We haven't met since the November MAC meeting.

DR. PARTIN: Thank you. Pharmacy.

MS. HUGHES: They met but did not have any recommendations.

DR. PARTIN: Optometry.

DR. COMPTON: We have not met. We meet again February 6th.

DR. PARTIN: Nursing. The Nursing TAC did not meet. Intellectual and Developmental Disabilities.

MS. HUGHES: They did meet but they did not have recommendations.

DR. PARTIN: Hospital.

MR. CARLE: Hospital did not meet and we have no recommendations at this time.

DR. PARTIN: Home Health.

MS. STEWART: We did meet but we have no recommendations at this time.

DR. PARTIN: Nursing Home.

MR. TRUMBO: We did meet. The Nursing Facility TAC met on Tuesday of this week in Frankfort.

After the TAC committee introductions and approval of the minutes, TAC Chairman Terry Skaggs recapped our last meeting, noting the Association and the State were in agreement to move ahead on increasing the provider tax with all proceeds being used to increase the price.

We discussed the quality component which would utilize a portion of the funds for quality improvement and requested we move ahead with an effective date of July 1st, 2020.

We also referenced we were in agreement to obtain an inflationary increase in the price and asked for an increase effective in July as well.

Next, we asked the Department

for Medicaid Services if they will continue with the RUG-III until September 30, 2020 and whether the Department will implement the Patient-Driven Payment Model or PDPM effective October 1st, 2020. According to Myers & Stauffer, it is too early to move forward with this new system for Medicaid purposes.

CMS will eliminate Section G from the MDS data set effective October 1st, 2020. As a result, Myers & Stauffer suggested the State may want to implement the optional state assessment which is used to document care provided to Medicaid residents beginning July 1st or October 1st of 2020.

We discussed the Kentucky Level-of-Care System or KLOCS next and the State plans on implementing the system April 3rd, 2020.

Deloitte has reached out to the Association and will be using webinar and onsite provider training in several locations around the state prior to and following implementation of the KLOCS to assist providers with the new system.

Next, the TAC discussed issues with utilizing Benefind to admit residents into nursing facilities. The system has been difficult to use due to member mismatches and issues that arise when someone from the community is admitted and

already has Medicaid benefits.

The Association asked the Department for Medicaid Services if a small group training session could be arranged to assist providers in using Benefind. This would cut down on the time it takes to obtain Medicaid eligibility once someone is admitted to a nursing facility.

Last, the TAC mentioned several nursing facility providers had experienced Medicaid transportation issues and contact information was shared for several Medicaid personnel for emergency and non-emergency issues.

In addition, a contact with the Department of Transportation was given and members can contact the Association for assistance when the problems arise.

The next Nursing Facility TAC meeting will be Tuesday, April 7th at 1:00 and this concludes our report unless there are any questions.

DR. PARTIN: Thank you. Dental.

MS. HUGHES: They did meet but no recommendations.

DR. PARTIN: Consumer Rights and Client Needs.

MS. BEAUREGARD: Good morning.

My name is Emily Beauregard. I'm the Chair of the Consumer TAC and we did have a meeting on December 17th. We had a quorum present and this was a really productive meeting.

We addressed many of the longstanding issues that have been on our agenda and some of the questions that we had had for a number of months. And, so, we felt good about this meeting and really appreciated the number of staff that were there for the meeting.

We discussed a number of the topics that we've talked about here before but were able to get more of the information that we needed and also make some more progress in terms of the consumer needs' area.

So, with Medicaid Free Care which we've talked about here in these meetings, this is an area where we really feel like there's a great opportunity for the State to address care needs, especially gaps in care, health disparities in schools, serving students throughout the state and finding opportunities to provide additional services that are Medicaid eligible.

And, so, we're very happy that the State has pursued this and we have been

supportive of this from the minute that we heard that they were working on getting approval for reversing this rule which had not allowed services to be provided in schools up until this point.

So, we have also been asking that we get more stakeholder input into the process. We always think that is helpful for a buy-in and making implementation smooth, making sure that everyone is at the table from the beginning or early on in the process.

And I'm glad to report that there is a stakeholder meeting that's been scheduled for January 30th. So, we're looking forward to learning more about where the State is in the process and how stakeholders can provide input and be involved to help make this a success.

ADA compliance has come up a lot. We have probably been talking about it for over a year at this point. We have raised concerns with the Cabinet's compliance with the ADA, not with the physical building or parking accessibility.

It was the compliance with helping people who have disabilities to fully participate, meaningfully participate in advisory capacities such as what you're doing here and what we

do with the TAC.

And, so, we were also very pleased to hear at the last meeting that then Acting Commissioner Bates had given the directive to staff to ensure that whatever access, whatever services are needed for TAC and MAC advisory participation would be provided.

So, what that means is that people with disabilities can have the personal assistance, the interpretive services and other types of assistance that they need in order to attend meetings in person and participate.

And we think that that will mean that more people with disabilities can participate on various advisory committees, the TACs and the MAC, and that will be a really positive thing for people who have Medicaid services and rely on these programs.

In terms of open enrollment and Public Charge, open enrollment, of course, closed since our last meeting, and the Public Charge Rule has been something that has actually provided or really created, I should say, a chilling effect on enrollment and public programs such as Medicaid.

And that's because a lot of

people who are legally residing in this country don't realize that the Public Charge Rule may not actually apply to them or to their family members, especially their children. They assume that it applies and they're afraid that they could lose their immigration status of not be able to become full citizens if they do enroll in a public program like Medicaid.

And, so, we wanted to make sure that we clarified that for people. We weren't able to do that during open enrollment, unfortunately.

We did that in a lot of our social media messaging, but as far as like an official statement from the State, from the Medicaid Department, we weren't able to get that done in time for open enrollment, but there is a plan in place and the Department has agreed to release or to distribute a letter that is being written by the Kentucky Equal Justice Center and the Kentucky Office for Refugees.

I think it's being reviewed by some Legal Departments right now. And, so, that letter is going to be forthcoming and we're excited to work with the Cabinet to make sure that people really do know what benefits they are eligible for and be able to encourage them to apply without being afraid, especially for their children but also for a

lot of legally-residing adults.

We've seen a decrease in enrollment with children, and, so, we think that having a chilling effect could be one of the things that is causing that decrease.

With Kentucky HEALTH, I think we all know that the Kentucky HEALTH waiver has now been rescinded, but we were very happy to learn that the substance use disorder services are going to be maintained. That was a part of the Kentucky HEALTH program but that's something that can operate without that waiver.

And, so, we were very happy when we got confirmation from the State that they plan to continue that expanded SUD treatment.

And the KI-HIPP Program which we have talked about here before, too, which is premium assistance for employer-sponsored insurance to Medicaid-eligible individuals or households, that program is also continuing.

We have expressed in these meetings some concerns about unintentional parts of the program that could unintentionally create cost barriers or network-related barriers, and we really appreciate that DMS has listened to those concerns

and been very responsive.

So, there's been some opportunity to work on the regulation and that regulation is open now. So, I'm hoping that we can address most of those issues and have a KI-HIPP Program that will work for more people.

In terms of Call Centers, this is a new issue that's come up. We've talked about the Call Centers from time to time and wait times and customer service generally, but this was an agenda item that we hadn't had before and we had a lengthy discussion concerning the wait times, customer service.

We regularly hear from beneficiaries and Application Assisters who wait anywhere from thirty minutes to two hours. Sometimes they end up being disconnected. They often hear a message that says that the call volume is too high, to call back later.

Actually, in December, at the end of the month, there were so many tasks to be processed by the people working in the Cabinet that they decided that they just couldn't answer the phones for a few days.

And we understand that because

the tasks being processed meant that people were going to keep their coverage. We don't want people to lose their coverage because tasks didn't get processed in time, but this is all an issue that we really hope we can work on improving and work in partnership with the Cabinet to do that.

So, one thing that we learned that was I think news to most of us was that there are actually five separate Call Center lines under the Cabinet.

So, there's one for DCBS, one for Medicaid Services but people with Medicaid coverage often call DCBS for certain things like eligibility and enrollment-related issues and, then, there's a KI-HIPP line. There's a line for the 1915(c) waivers and there's another one that I'm not recalling at the moment but five that we were able to collectively count in that meeting.

And while we understand that there may be a need for these various lines, there's not a real clear way for people to understand what number to call for what issue. And, so, we think that there's a lot of confusion and difficulty navigating these phone lines.

The decision trees that you get

whenever you're having to select different numbers for what issue that you're calling for can be confusing.

And, so, we asked if there had been any consumer input into designing these Call Centers and the various phone trees and there wasn't a clear answer. It seemed like people weren't quite sure if consumers had ever had input into the process but that's something that we think would really help and be beneficial.

And we also suggested that there just be a one-page listing that could be both mailed out but also online where all of the various Call Centers and the issues that you would be calling for are there in one place just to make it easier for people to identify and quickly figure out which direction they need to go.

An issue that was actually raised by Dr. Wright at the last MAC meeting was something that we put on our agenda. We requested clarification on the provision of respite care funds for the 1915(c) waiver beneficiaries.

And we learned that the respite funds for the Michelle P. Waiver are based on the calendar year which can be an issue. Pam Smith did

acknowledge that this makes it difficult to track. They're working on a policy statement she said or to write a policy statement that would base respite funds on the plan-of-care year and that would, I think, improve things greatly, it sounds like.

And we understand that a permanent fix is going to go into place in July of this year with new regulations, but for now, it sounds like that this policy statement would help between now and July to make sure that kids are getting their respite care.

In terms of mandatory copays, that's an issue that again has been on the agenda since we learned that the Cabinet was changing that rule and making copays mandatory rather than optional.

So, we learned of that in late 2018, and we have expressed our concerns about the negative impact of mandatory copays, people being turned away when they need care or maybe even just avoiding going to the doctor or going to a provider at all, not getting all their medications filled.

And we have been able throughout the year to document a number of these issues that people did experience. And, so, we were

thrilled to learn that DMS is planning to file regulations to make these copays again optional. So, they would be optional for the MCO to choose to charge or not charge and that's essentially what the rule was or what the policy was before 2019.

So, a lot of good news from that meeting. We do have two recommendations. One recommendation is to create an advisory committee with beneficiaries to provide input into the Call Centers' operations and that we ask that DMS request both Conduit and DCBS to participate because Conduit is a contractor. DCBS is obviously another department.

And since they take on some of that Medicaid work with eligibility and enrollment, we wanted to make sure that we had more of a comprehensive and overarching group of department staff that could work with us on this.

And, then, we had a recommendation that DMS provide a written policy that addresses how it complies with the ADA by paying for or providing appropriate accommodations for people with disabilities to allow them to fully participate in meetings as a person serving in an advisory capacity, specifically addressing the need for

personal assistance, transportation assistance, interpretive services and other accommodations as necessary. So, those were the two that we had.

Our next TAC meeting will be on February 18th at 1:30, and this year we're meeting at the Cabinet in the Cafeteria Conference Room for all of our meetings. I'm happy to answer any questions.

DR. PARTIN: I have a couple of questions. On the topic of people not signing up, especially with their children, for Medicaid services because they're afraid of deportation or something like that, does that cover people who are here illegally but their children are citizens?

MS. BEAUREGARD: Are here legally, yes. So, we have a lot of mixed households, people who are undocumented living with, like you said, children who may have been born here in the United States.

And those children are, of course, eligible for Medicaid benefits and we want to encourage them to be enrolled and be healthy, have access to health care, and parents can be very afraid that if they enroll their children, that it will affect their status.

And we want to make sure that

we're not having this unnecessary fear, of course. We think that all children, of course, should have coverage. Most children are legally residing, and whether you're a mixed household or not, having people who are legally residing enrolled in benefits should not affect other people's status, if that makes sense.

DR. PARTIN: But it could, right? It could.

MS. BEAUREGARD: My understanding of the Public Charge Rule is that it affects a much narrower population than we understand.

And I'm not the expert on this. So, if you wanted to learn more about it, I could invite somebody or recommend someone that could come to the next MAC meeting to talk more about it, but my understanding is that it doesn't apply to as many people as the public generally understands.

And a lot of these immigrant families are being told by attorneys that the safest thing to do, to be extra cautious, just don't let anyone enroll in public benefit programs.

For them, that's kind of the blanket, you know, this is going to mean that we

don't have to essentially worry about this Public Charge Rule in effect to your case, but the truth of the matter is that's overly cautious and it's creating more fear than is necessary and really a misunderstanding of the Public Charge Rule.

So, the letter should be able to clarify who is eligible and who should be able to apply without any fear of losing their status.

DR. PARTIN: I would like to learn more about that but I don't want to take up time from the group if you all don't have any interest in it.

DR. ROBERTS: I'd like to hear more.

MS. BEAUREGARD: Okay. Then, I will recommend someone that can come and speak to you at the next meeting.

DR. PARTIN: Okay. And, Sharley, we'll put that on the agenda, then, whoever can come to talk to us about that.

MS. BEAUREGARD: Did you all have another question?

DR. PARTIN: I had another question on the copays. You were talking about the MCOs and this probably needs to go to DMS rather than

you, but if the MCO does not require the copay, then, does the provider receive the full reimbursement?

COMMISSIONER LEE: Yes.

MR. CARLE: This is something that Emily mentioned - a patient advisory council. Other than having potential Medicaid patients on this Council, is there anything else that Medicaid has to get direct feedback from participants, enrollees?

MS. BATES: Generally, it just happens when we have a certain project, for example, 1915(c) waiver redesign, when Kentucky HEALTH was going on. So, generally, it's specific to a project, KI-HIPP and those types of things, so, not really a general advisory.

I know that there are a couple of TACs where we have members that could be on the TACs but sometimes it's a challenge to get there.

MS. HUGHES: It's like the Consumer TAC. You can have consumers of Medicaid on it. The TACs, it's dependent upon the association. They're the ones that pick who they want to represent them on the TAC. The State doesn't. Except for four TAC members on the IDD TAC, all the rest of the TAC members are represented by whomever the associations pick.

MR. CARLE: Okay. We just found in the health care field, the hospital field specifically, we found tremendous benefit of developing patient advisory councils with patients that actually have experienced that and we use them as a sounding board as to how we can better the services that we render.

So, when you brought it up, that's what made we think of that.

MS. BEAUREGARD: Yes. I would agree with that.

MR. WRIGHT: And, Chris, to go along with that, even some like summative feedback year end to year end could be done potentially.

I think we as a group provide feedback as well from what we hear from our patients or our clients or our families, but it would be nice to be able to have some evaluated measures or metrics that would come in from a much broader group of individuals, and I would say it could be done by electronic means through providing some feedback forms through survey analysis or things of that nature related to client care and patient care services.

I had three things I wanted to

kind of highlight and talk about with relation to your report.

Questions, just hypothetically thinking about Benefind versus Kynect, has there been any conversations initially related to the way to enroll members? As we found, I personally have found the Benefind portal not to be so user-friendly, so, just thinking about that.

With the KI-HIPP and the transition, has there been any initial feedback that you could provide? Since the transition now has taken place in January, I received a couple of documents that were mailed to me related to the KI-HIPP and one of which was related to January premiums that had not - there was actually kind of like a naughty letter that I received. You haven't received your January premium request for payment, but we don't get those until the end of the month. So, I'm just checking in on that.

And, then, with regard to enrolling for memberships into Medicaid through the 1915 versus any type of other Medicaid programs, particularly those members who have intellectual and developmental disabilities, is there any ongoing training about how that process works with medical

teaming because we're seeing a lot of issues and I'm hearing a lot of issues about people receiving letters about enrollment, that they're no longer eligible for Medicaid services that were receiving 1915 Michelle P. Waiver services. Just a thought.

COMMISSIONER LEE: You had several questions in there, several statements.

MR. WRIGHT: Sorry. I'm just throwing it out there.

COMMISSIONER BATES: The enrollment piece, you talked about Benefind. I think Lee Guice is our eligibility expert and she can kind of talk to you a little bit about Benefind. And, then, Stephanie, I think, has some information on the 1915(c).

MS. GUICE: We do currently have a project in place to update the self-service portal. It has been ongoing behind the scenes. There's been a lot of research done and we are not clear at this moment in time when that redesigned product will be available.

So, we haven't made any announcements. There's nothing out about it. And you know with government, at any time, something could crash and burn until it's implemented.

So, I don't want to promise it's coming but there is certainly an awareness throughout all of the Cabinet that the self-service portal known as Benefind or Kynect - Kynect has been gone for four years, so, it's not Kynect anymore - but there is an awareness that Benefind is under-utilized and probably under-utilized because it's a little difficult for users. So, there's that.

MR. WRIGHT: Let me ask. Is that going to be a contractual or is it in-house type of work that's being done on that project?

MS. GUICE: Well, whenever technology is involved, 99% of the time, it's contracted out to another vendor.

MR. TRUMBO: Who is that?

MS. GUICE: That's working on the project? Deloitte because they built the rest of the system.

MR. TRUMBO: They don't have any timelines or parameters they're trying to meet?

MS. GUICE: The reason that I cannot tell you what the implementation date is is because we don't know just yet. We're not far enough into the project to say, yes, we're finished and we anticipate implementation on this date. We're not

far enough into the project at this point.

MR. TRUMBO: So, it's still kind of in the design phase?

MS. GUICE: Yes, it's in the design phase.

So, I think that's going to help quite a bit. One of the things I think that's going to help the most is that it's going to be much more mobile-friendly.

And, so, I'm very excited about that and am very hopeful that, particularly with the new Administration, there will be a lot of outreach and education in order to try to help folks really use this new product when it's rolled out.

What else? Is there anything else I can respond to you about?

MR. WRIGHT: That answers that question. The two other were related to KI-HIPP and the transition.

MS. GUICE: Okay. The letter that you got sounds to me like a reminder which it goes out automatically if the task hasn't been worked that you have already made your submission. It's just a reminder.

MS. BATES: And I was just going

to kind of piggyback on what Lee was saying is that there has been a push here over the past month or so to really look at the portals and how they're not necessarily user-friendly and how even myself, I would probably give up.

So, I think that there really will be a big focus on making all of that user-friendly just because it will help ease up the problems at the DCBS office and the places out in the state. And, so, we're aware of that and really that's part of this project.

MS. GUICE: And fewer telephone calls.

MS. BATES: Yes, fewer telephone calls that deals with the Call Center, I mean, just making that easier. In today's world of going online and doing everything really will help, I believe, the other issues.

And, then, I did want to say also with regard to that that there is going to be just a really heavy focus on getting out there and getting people enrolled because we know that there have been some barriers out there just because that's one of them; but focusing on getting people that are eligible for Medicaid enrolled is going to be very

important. So, you will start to see some things.

I did want to go back a little bit to the question about consumer input into things, into their services and all of that.

The MCOs are required to do certain surveys. They have a ton of requirements that are out there. We have CAHPS surveys. There's other surveys but they are very specific surveys, different ones, some about providers, some about the plans and some about their care.

So, there are a lot of ways for MCO beneficiaries to give input. I just wanted to put that out there. I didn't think of it until we had moved on.

And, then, what was your question about the 1915(c)?

MR. WRIGHT: I've been heavily involved in a support group for parents who have children with intellectual and developmental disabilities, and I experienced it personally this year but was able to negotiate that with help fromthe Department, but, then, a very close family who experienced - they're on the Michelle P. Waiver. They submitted all the documentation.

They get approval letters and,

then, they will get a letter saying that they have been disenrolled for services.

MS. BATES: That kind of stuff actually happens outside of the waivers, too. So, I guess we would have to take things on a case-by-case basis. I don't know of any issue with any kind of eligibility system stuff.

MS. GUICE: Right. I don't know of any big glitch that started. So, specifics.

MR. WRIGHT: In a couple of instances, it's just improper coding. So, I think it's being at the DCBS level coded, like they should be coming in and receiving services through the 1115(c) waiver----

MS. BATES: 1915(c).

MR. WRIGHT: Instead of the 1915(c) but they're getting coded to it. When Benefind is going through the process or it's coming in to DCBS, they're not getting connected to the persons who are working with 1915(c) approvals but they're looking for----

MS. BATES: You'll have to send those to us. Usually if there's a big problem systemwide, we would know that but we don't know of anything like that now. So, if you don't mind to

share those with us because we don't want there to be any kind of barrier or false positive or anything like that, right?

MR. WRIGHT: Yes. Thank you.

DR. PARTIN: Behavioral Health.

DR. SCHUSTER: We had an excellent meeting on January 8th. We had a quorum. All five of the MCOs were there and we had DMS staff and DBH/DID staff. So, we were very pleased about that. We approved the minutes and so forth.

The Humana Medicaid MCO is now operating in place of CareSource. So, we gave them time to introduce themselves to the TAC members and we had about thirty other people there from the behavioral health community and they gave us some very helpful information about contacts and people and their provider resource guide and so forth.

We have had a real problem with case management. And for those of you who know anything about people with behavioral health disorders, I would say next to the appropriate medication, case management is the lifeline to keep people out of the hospital.

So, that's the kind of guardrails we call them out in the community to make

sure that people are keeping on their medication and getting their services that they need and so forth and are not starting into that downward spiral that gets them in and out and in and out of the psych hospital or into jail or into homelessness and so forth.

And we are having a lot of problems and we had some providers there from the community mental health centers primarily but also from the hospital on talking about how hard it's been to get case management approved by the MCOs.

And, so, we had asked each of the MCOs to come and tell us how they were doing that and it was kind of a split. Several of the MCOs were not doing any prior authorization, so, they were seeing it as what we might call a core service and they were approving it each time the request had come in.

There were also MCOs that were applying medical necessity criteria and were ratcheting down on the amount of case management that was being given.

We had a meeting out in one of our community mental health centers in a rural area where they had had six or seven case managers there

and they're down to two case managers because they're having so few case management services approved and their case load is not down. I mean, the number of people that they're seeing with severe mental illness has not decreased but that's how few services are being approved.

So, we had a big discussion. It was pointed out that if you look at the regulation that defines case management - it's a DMS regulation - there's nothing in there about medical necessity being a criteria. It talks about what the purposes of case management are and who can do it.

So, we're not sure that it's appropriate, quite frankly, that case management is being used by some of the MCOs because it's really funneling, it's really stopping this lifeline.

Dr. Brenzel, the Medical Director from DBH, said that they were looking at it. They wanted to look at some trend data. We argued, the providers and the consumers at the TAC argued that we do see this as a core service from the community mental health centers, and I think we had some agreement from DBH about that.

We were delighted that Stephanie Bates who was there from DMS said let me

step forward and let me gather from the MCOs what medical criteria they're using and what data we can get to see what's really going on here.

One of the MCOs said that their data showed that even though people were getting case management, they were still ending up in the hospital.

So, we need to look at that data from all sides, but we were delighted to have a forum which I think really is the purpose of the TAC to really bring everybody together and to look at that data. It was really the leadership from DMS that is going to make that possible.

So, we're particularly grateful for that and we will have that on our agenda for our March meeting.

Stephanie also gave us an update on changes in personnel over at the Cabinet and so forth, gave us the excellent news about a change in the regulation about copays.

Probably of all the TACs other than the Consumer and Clients Rights TAC, we probably have raised the issue of the negative effect of copays because we know that people are not showing up for their appointments because they don't want to be

asked for that $3 when they know they don't have it in their pocket, even though they're getting the services, but it's just an embarrassment. So, we're delighted that that reg is going into effect.

We were glad to have Pam Smith there also to give us an update on the 1915(c) waivers that have been going on.

We always have a report from brain injury advocates and providers, and there certainly has been some push-back against the rate recommendations in the 1915(c) waiver redesign.

When you have the same pie, as you all know, and you do a rate study, there's going to be some winners and some losers.

And the big, big losers in that were the ABI or the acquired brain injury waivers and they feel like they're stretched as it is, and to decrease the amount of funding over there to put it over in some of the other waivers was really problematic. So, I hope that that will continue to be looked at.

We talked about single-entity credentialing service and Stephanie gave us an update on that RFP.

Nina Eisner from The Ridge is

an active member of our group that meets around the TAC and she talked about the importance of a single medical necessity criteria which is what we have been pushing for in legislation. We're waiting for the Department of Insurance, I guess, to make a recommendation of what that should be.

We also came back to a very important issue that I've talked to you all about and that is this problem with the ambulance transportation hospital to hospital, so, a hospital that doesn't have psych services needs to take a patient with a mental illness over to a hospital that does. I think, Dr. Partin, that you mentioned that it happens even from medical offices.

And it may very well be that we need to look at that regulation because the regulation talks about transporting someone on a gurney, and it may be that if you've got an ambulatory patient essentially, that there is a problem there.

I was delighted to hear from Nina Eisner that there's a subgroup at the Kentucky Hospital Association that is looking specifically at transportation issues and she will keep us informed of those findings.

And I think some other TACs have talked about transportation is such a huge issue I think for all of us, particularly out in the rural areas but even in the urban areas.

Our recommendation is one that we've made probably nineteen times before, and apparently there is great movement now at DMS, so, I'm thrilled, and that is that we have a single formulary.

How many times have you heard me say how difficult, how difficult it is for our providers, our prescribers who are so rare to find. It's so hard to find a psychiatrist or a psychiatric NP in this state that's willing to work at a comp care center primarily or in other settings and has to deal with five different formularies, five different PDLs and five different criteria for prior authorizations. And, so, people are not getting prescribed we think the very best medication for them.

So, we are thrilled; and if we can help push that over the line, we're here to help push.

Again, we want to express our appreciation for the changes in dropping the copay

requirement for DMS staff and certainly for their looking at the case management issues.

Our next meeting will be on Wednesday, March 11th at 2:00 and we meet in Room 125 of the Capitol Annex, and I'm happy to answer any questions. We all decided it was the best meeting we've had in ages. It was very uplifting, very good for our mental health actually. Any questions?

DR. PARTIN: No.

DR. SCHUSTER: Okay. Thank you very much.

DR. PARTIN: So, we need to take a vote to accept the reports and recommendations from the TACs. Would someone like to make a motion?

MR. TRUMBO: So moved.

MR. CARLE: Second.

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

New Business. We need to start working on scheduling the MCOs to come and talk to us again and give us updates. So, Sharley, could you start working on that?

MS. HUGHES: What type of information are you requesting from these MCOs?

MR. CARLE: Same information that we had last year. I would like to add their patient satisfaction information. Thank you, Stephanie, for bringing that up. They all had a standard format that we used. The first year we did this, we started at the beginning of the alphabet and then we went to the back of the alphabet. Just mix them up.

MS. HUGHES: Okay.

MS. STEWART: Remind them that we were interested in denial percentages as well, if you would.

DR. PARTIN: So, coming up at our next meeting, at our next meeting, we will have somebody come and talk to us about the undocumented people who basically have children who are citizens and about them enrolling in Medicaid.

And, then, we will begin scheduling the MCOs also to come and make presentations.

MS. HUGHES: And your next meeting is at the CHFS Building because we couldn't get the Annex. You have to come in the main entrance as you always come in.

DR. PARTIN: Any other business?

MS. ALDRIDGE: I need to add Peggy Roark as attending. She came in.

DR. PARTIN: So, Teresa is noting that Peggy came in and we're going to add her to the list of attendees.

If there's no other business, then, if someone will make a motion to adjourn.

MR. CARLE: So moved.

MS. ALDRIDGE: Second.

DR. PARTIN: All in favor?

MEETING ADJOURNED