CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

March 25, 2021
10:15 A.M.
(All Participants Appeared via Zoom or Telephonically)

MEETING

APPEARANCES

Elizabeth Partin
CHAIR

Nina Eisner
Steven Compton
Susan Stewart
Jerry Roberts
Catherine Hanna
Ashima Gupta
Ann-Tyler Morgan
Garth Bobrowski
John Muller
Peggy Roark (telephonic)
COUNCIL MEMBERS PRESENT

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AGENDA

1. Call to order .....(not recorded)

2. Roll Call (QUORUM PRESENT).....(not recorded)

3. Approval of minutes from January meeting (APPROVED).....(not recorded)

4. Old Business
   A. What State Plan Amendments (SPAs) to incorporate changes made under emergency orders have been submitted to CMS? (not recorded)
   B. Update on 1115 Waiver for treating incarcerated people submission to CMS .....(not recorded)
   C. Reimbursement for more than one visit per day for Medicaid recipients (i.e. primary care and specialty care).....(not recorded)
   D. Request amendment to the Rural Health Clinic regulation 907 KAR 1:082 Section 9(1)(b) 2 (on page 16) to extend the time to three days for providers to sign Medicaid participant's chart. The current regulation requires charts to be signed on the day services are provided. Three days would be in line with other regulations and more realistic in busy clinic settings..(not recorded)
   E. Hospital Reimbursement Improvement Program – More in-depth about what it is and what it means for Kentucky going forward..... 4 - 11
   F. Information technology modular components – How will it impact DMS, providers and Medicaid participants? ..... 11 - 13
   G. Electronic Visit Verification. – What is this and how will it affect providers?..... 13 - 17
   H. Low birth weight babies – Has DMS acted on any of the suggestions from the MAC at the last meeting? FYI - HB 212 (Rep Heavrin) Amend KRS 211.684 to require the child and maternal fatality annual report to do a demographic analysis by race, income, and geography and require the annual report be sent to the Interim Joint Committee on Health, Welfare, and Family Services. PASSED ..... 17 - 38

AGENDA
(Continued)

COURT REPORTER'S NOTE:) Due to technical difficulties with Zoom and the wrong Meeting ID number, the beginning of the meeting was not recorded. The recording started with discussion of Item 4E on the agenda.)

DR. PARTIN: Okay. Hospital Reimbursement Improvement Program. This was brought up at the last meeting, and I believe, Commissioner, you said that if we wanted more information, that we could ask for it for this meeting. So, that's what this item is.

COMMISSIONER LEE: And I believe Steve Bechtel is here and he can speak to this. And I'm not sure. He may have a presentation, but if not, he will be able to give you a little bit of background about the HRIP program.

MR. BECHTEL: Thank you. Again, I'm Steve Bechtel, Chief Financial Officer for the Department for Medicaid.

Let me give you a little brief history real quick on managed care directed payments. The programs themselves, Directed Payments Programs, were created by CMS through the Managed Care Final Rule back in 2016, and these programs generally allow states with Managed Care Programs to enhance payments

to providers to advance goals of the Medicaid Program.

They're normally designed to advance at least one goal of the State Medicaid Programs' Quality Strategy with appropriate oversight to evaluate the progress on those goals and they have to be approved yearly through CMS.

So, I just wanted to give you that brief history of what those are and where this came from.

And, so, we were approached by KHA, the Kentucky Hospital Association, and we worked collaboratively with them on it's called the Hospital Rate Improvement Program. I'm going to call it HRIP for short, if that's okay.

The HRIP Program was initially authorized through House Bill 320 back in the 2019 General Session, and it was effective 7/1 of '19 with the following things.

It provided enhanced payments made for inpatient hospital services up to the Medicare upper payment limit which is the UPL amount that we can go up to normally on the fee-for-service side of things.

It provided increased

reimbursement to our Kentucky hospitals of approximately $100 million to $125 million annually, and the hospital funded the state's share of those expenditures through a hospital provider tax assessment.

The program was designed really to ensure access to hospital care for Medicaid members and to lower the hospital readmission rate.

And that was House Bill 320 that was effective 7/1 of '19 through June 30th of '20. Like I told you earlier, we have to get this approved yearly through CMS.

And, so, this year, what we did this year, we got it approved again for the state fiscal year '21; but KHA and us, we came together again to look to see how we can, because our hospitals are struggling. We had some rural hospitals that were really struggling financially. So, we wanted to see if there was a way that we can expand that program again a little more.

And, so, on January the 14th of this year, '21, CMS approved a revision of the HRIP Program which significantly increased the inpatient reimbursement to our Kentucky hospitals.

And the way we did that was we

changed the methodology from an upper payment limit methodology to an average commercial rate. Now, we can do that through the managed care side of things; but on fee-for-service, we still cannot exceed the upper payment limit.

So, on the managed care expenditures, we were allowed to go up to the average commercial rate. And what that did, it did create a couple of additional quality measurements that we have to meet that the hospitals need to shoot their targets on, and those were two opioid-related metrics that we added to that program, and we got that backdated to 7/1 of '20.

So, we are waiting. And some of you all may have known, in House Bill 192 this year - let me back up. The change of this program is in House Bill 183 that was put in this year, into legislation. So, you can look at House Bill 183. It's been passed and signed by the Governor. And, then, it passed unanimously with the House and the Senate, I might add.

So, we're real excited. It's been a program that we have been able to work directly with the Hospital Association, with some hospitals, as well as consultants. It's been a good

program to where we have come together which is what I think we need to do with everything. We need to come together and look at the common goals and how we can better serve our members and serve the citizens of Kentucky.

I will say that moving to the House Bill 183 methodology of average commercial rate - I hope I'm not confusing you all with all these House bills - but when we moved to that, it did increase, like I said, substantially the amount of money that is being funneled to our hospitals. It increased that funding by about $800 million, and that's net. That's after the taxes they pay.

So, it is a program that we're able to do some economic stimulus type of things within our program and still to help our struggling providers and struggling hospitals to make sure that we have that access of care for our members.

I will state that House Bill 192 - I'm going to throw one more at you - House Bill 192 is the budget bill and it is in that appropriation once that is passed and signed by the Governor and it goes through all the processes it needs to go through.

Once we get that, we will have

the appropriations and we will be going back - I think we have a target date of April 15th to start going back and reconciling the quarter one payments, and, then, quarter two will follow right after that.

And what I mean by that is we've already paid the quarter one and quarter two payments under the old methodology, the UPL; but once we get the appropriations, we already have House Bill 183 approved. We already have approval by CMS to process. I just need the appropriation levels.

Once we get those appropriation levels, I will be able to go and start processing those increased payments to our hospitals.

That being said, I will allow anybody to ask me a question. I know I've probably confused you with a lot of the House bill talk; but if I have any questions, I'll be glad to entertain them.

DR. BOBROWSKI: Steve, I have a question. You said it has to be approved annually. Which organization, who do you go through to get that approval?

MR. BECHTEL: I have to get the approval through the Centers for Medicare and Medicaid Services but we work collaboratively. We

have a workgroup that meets every week. And on that workgroup is members of the Kentucky Hospital Association and members of their consultants from Health Management Association and my consultants with Myers & Stauffer, my staff. We have all stakeholders represented in that meeting to where we can figure out and we also have members of our Quality staff as well on there.

Just to let you all know that it is not something that we're just doing. We are talking with KHA heavily on this program.

Now, let me just expand on one more thing on that. We are in the process of asking now for a three-year approval. You can do a three-year approval through CMS.

So, we are now trying to work on the preprint for the next three years because we heard and listened at some of our hospitals. They don't want to depend on that money and then it not get approved and things like that.

So, we are now asking for a three-year approval so that we can give some stability on the budget side of things for our hospitals.

I can't say that CMS will

approve that but we are asking for that. So, let me caveat that.

DR. BOBROWSKI: For any business entity, if you get that three-year approval, that really helps with any business entity on budgeting and planning for the next year.

So, I'm sure you've got it in there that even if you do get a three-year approval, that maybe that approval request will be a year or two years ahead of the actual date so that they can go with their budgeting.

MR. BECHTEL: Correct. We're actually doing a three-year. We're still going to submit a request every year with a rolling third year, if that makes sense, so that we can always be about two or three years ahead of the game.

DR. BOBROWSKI: Thank you.

DR. PARTIN: Thank you. Any other questions? Thanks a lot. That was very helpful.

Next up is information technology modular components, how will it impact DMS, providers and Medicaid participants? And, again, this is from information that we received at the last meeting and we were invited to ask for more

information.

COMMISSIONER LEE: Basically, what we're doing is modernizing our Medicaid information system. Sometimes it can be quite difficult to be flexible with our technology when everything is housed in one big system.

So, over the past twenty years, CMS has emphasized modularity which basically means using a lot of little smaller systems that work together rather than one really big system.

So, I think there's about fourteen modules and it will make the members' lives and the providers' lives a little bit easier, I think. You all have seen some of the modular components, for example, in the provider portal.

We also have our eligibility and enrollment system, the claims payment module, a member benefit module, our Electronic Visit Verification which you will hear a little bit about a little bit later in the presentation today, financial management, those sorts of things.

And, so, basically, these different solutions or platforms house information and they talk together and it will allow us to be more flexible with changes to the system and

facilitate reporting.

The eligibility and enrollment system, for example, since we've got its own module, the members can actually go in, fill out an application and upload information. So, the modularity is just going to make our lives I think a bit easier and make reporting easier as we go forward.

And if you'd like a more detailed or in-depth presentation, we could ask someone from our Information Technology area to come and give a bigger presentation, but basically it's just moving away from one system to smaller systems that are easier to maintain and easier to change in the event that we need to.

DR. PARTIN: Okay. That's very helpful for me. Does anybody want any more in-depth information about that? Thank you.

Next up is the Electronic Visit Verification. What is this and how will it affect providers?

COMMISSIONER LEE: The Electronic Visit Verification, it's one of our fourteen modules that we have. Pam Smith oversees that project and she can give you a high-level update

on that project.

MS. SMITH: Thank you, Commissioner. So, as the Commissioner mentioned, Electronic Visit Verification, it is a system that's mandated in the 21st Century CARES Act to capture six elements that basically ensure that individuals are receiving their home-based services on time and that it actually is them receiving them by the individual that is scheduled to provide those services.

Our state vendor that we selected, we have an open model which means that we have a state-provided vendor which is Tellus or the providers can bring their own.

And, so, we do have thirteen other EVV vendors that are in the state that serve various providers, but all of them submit information to the Tellus system as our aggregator so that we're able to monitor that data.

We went live in the beginning of November and have just recently went on a pause. We were having some repeated problems and some instability in the system. So, we did institute a pause for the providers, that they can choose to continue using the system right now, and many of them are, or they can also revert back to kind of the

paper processes.

Right now, it's being used by our 1915(c)waiver populations and by 2023 will also include our home health, the MCOs for those home health type services, private-duty nursing as well as our Money-Follows-the-Person system.

But it does electronically collect the location of the service to make sure that actually the people are with the participant when they're saying they're providing services.

It collects the service that is being done, what task they complete when they're doing the service, as well as it verifies who the employee is, and the participant also or their authorized representative signs to confirm that that visit was, in fact, performed for them and that they agree with the information that's being submitted with the visit.

So, I will pause now for any questions.

DR. PARTIN: So, how do you verify? Does the provider submit information or do you somehow access electronic records? I don't know how that works.

MS. SMITH: So, there is a

mobile app that is either on a cell phone or a tablet device that the provider has with them. So, the visits are scheduled on that device. They check in and check out based on that schedule and, then, the service code is specified and, then, the tasks that they provide they either check or uncheck, depending on if they completed a task or if they didn't. They also have the opportunity to include notes, and, then, the location is GPS-verified.

So, when the visit, then, comes into the system and the administrator is looking at it, it shows if there was any variance in the location or if the service started late or if it ran over or if it was missed completely.

So, in a dashboard view as a provider and as the State, we can look at the dashboard and see that there's this many visits that are going on right now. There are this many that were late. There were this many that were completed but they were late and it gives that view to see overall. And, then, you can dive in a little bit deeper and look at each participant or each employee.

DR. PARTIN: Okay. So, it's like a combination. Do you use like the GPS on a person's phone to verify that they were there?

MS. SMITH: Yes. It uses that location. You have to specify when you're scheduling a visit the starting address and the ending address. And, so, it verifies the location at those two points. So, it will be a snapshot. It will capture it when they sign in and it will capture the GPS location when they sign out and, then, it displays the difference in the location.

So, for example, we have a geo fence or what is allowed to be the location range set up at a half a mile because sometimes that technology, you're not always right on top of that location.

So, if it is anything outside of that half-mile radius, then, it throws an error that the visit was not completed where it was expected to be done.

DR. PARTIN: Okay. And, so, this would be verified by, again, just for my understanding, by either their cell phone or their tablet that they carry with them?

MS. SMITH: Yes.

DR. PARTIN: Okay. Thank you. Any questions? Okay. Thank you.

Next up, at the last meeting,

we talked about low birthweight babies and we offered some suggestions for looking at that problem in the state.

And, then, also, I just placed on the agenda that House Bill 212 sponsored by Representative Heavrin had passed which is good because it will help the State collect data on low birthweight babies and also births by race, income and geography. So, I think that will be helpful in looking at that issue.

I was wondering if any of the suggestions that we made were looked into yet?

COMMISSIONER LEE: And I'd like to thank you for the recommendations. We have been looking at them, and Dr. Theriot has a presentation specifically for this topic. So, I will turn this over to Dr. Theriot.

DR. THERIOT: I'll try and share my screen. I just want to say I really appreciate the fact that you guys brought this up and it's something that we have been working on quite a bit over the last year or so.

So, I'm going to walk through a little bit of that Maternal Morbidity and Mortality Report that comes out and, then, some of the

information that we can get from it and other things that we're doing to address some of your recommendations.

First of all, the report that was mentioned is the annual report that the Department for Public Health, Division of Maternal and Child Health puts out, and the most recent report came out November of 2020 and it gives us a lot of good information about the mothers in our state.

The report comes from the Maternal Mortality Review Committee and that committee meets several times a year. I'm on the committee. It's a very depressing committee to be on, but the committee reviews every death in great detail of any mom that was pregnant at the time of death or pregnant within one year following the birth of the baby, and we look into every aspect that we can get our hands on to see what contributed to that death.

And you can see on the committee, we have obviously Public Health because they're leading the committee, but Medicaid, DCBS, BHDID, law enforcement, the KASPER folks, the Chief Medical Examiner, domestic violence and human trafficking. We even have a women's cardiology

specialist, a cardiologist that specializes in pregnant women and their heart issues. Birthing hospitals are on there, providers, controlled substance.

So, we can get information from all these places and we can all discuss what went on with each death and get a good look at what's happening with that.

From the report, the November 2020 report, you can see these are raw numbers of maternal deaths in our state and they're going up. In 2018, there were 76. And, again, these are deaths of moms between the ages of fifteen and fifty-five who were pregnant within one year prior to death or pregnant at the time of death from any cause.

They scan the surface of race. I know you had mentioned race and income and geography. I believe they have this information just from sitting on the committee.

In the most recent report, the only thing they really reported on was race, and you can see when you turn it into a race per 100,000 live births, black women had a much higher rate of maternal deaths than white women.

So, 42.1 per 100,000 for black

women compared to the 17.2 per 100,000 for white women. So, we have a bit discrepancy in our state based on race, and I don't think any of you guys would be surprised by that. It goes along with the national statistics.

But looking a little bit more at the deaths of the black moms, it's much higher in Lexington and in Louisville which is where our providers, our birthing hospitals, our regional referral centers are located.

So, that, to me, is a disconnect. I automatically think, oh, we're a rural state. The deaths must have something to do with access to care. Maybe people aren't getting the care; but, unfortunately, looking at these numbers, it's not an access-to-care issue. It is a care issue. The African-American moms are not getting the same care as the white moms.

So, that's something we really need to look at. We need to look at the services in our urban centers to see what's going on and what's causing that disconnect.

I know in Louisville, they have something called Healthy Start and it was built out of looking at the infant mortality rate but that goes

right along with maternal morbidity and mortality and it's a program that goes in to the homes and supports families, looks at the services, addresses social determinants of health in the ZIP Codes with the highest infant mortality rates in the city.

And, so, there's not a lot of data from that program yet but we're really looking at that to see what's going on and we're looking forward to see what they have to tell us.

The other thing the report does is look at the manner of deaths. Was it a natural death? And natural - I had a problem with this. Natural means like postpartum hemorrhage and, then, bled to death in the hospital or amniotic fluids, embolism or eclampsia or hypertension and seizures and death. So, those are the natural deaths.

And, then, you have your accidental deaths which it might be a car accident, something like that, and, then, you have your homicides and your suicides. So, all of the deaths that are reviewed are broken down by this.

More telling, I think, is was the death preventable? So, after we get all the information, the committee has to decide was this a preventable death or a non-preventable death? And

most of the time, deaths are preventable. Was it a homicide, a suicide? Was it a car accident? Those are preventable.

Looking at the natural deaths, was it a postpartum hemorrhage? Yes. That's preventable. You would kind of think that should never happen if you give birth in a hospital but it does.

And, so, I think this is kind of a horrifying slide but it also means that we could do something about it because if it's preventable, there's something we can do better. You just have to try and address the problem.

Then, being in Kentucky, we know we have a big substance use disorder issue and we looked at the deaths, the maternal deaths that had substance use as a contributing factor and it's about half. About half of those deaths have to do with substance use.

So, again, knowing this, I think we can move forward and put some things in place to help address this issue.

One of the key challenges for this population is postpartum care; and Dr. Partin, you brought this up at the last meeting is seeing

moms not only for prenatal care but for the postpartum visits and doing appropriate screenings - screening for postpartum depression, screening for substance use. And, of course, the whole point of screenings is to connect women with what they need.

One of the things our MCO partners are doing is they are providing care management for high-risk pregnancies, again, trying to connect women with what they need. And they're also providing incentives, the gift cards and things, for women attending a prenatal visit, as well as that all-important postnatal or postpartum visit.

Some of the other things that Medicaid has been doing is participated with Public Health in the OMNI Learning Community which is the Opioid Use Disorder, Maternal Outcomes and Neonatal Abstinence Syndrome Initiative. We just call it OMNI because that's a mouthful, but we were partnering not only with Public Health in this but with BHDID, DCBS, Primary Care Association, the Hospital Association to address issues about this.

And from the OMNI initiative came that Kentucky Perinatal Quality Collaborative that you mentioned in the last meeting. So, that grew out of OMNI and it's now in its second year and

that's a great initiative. We're getting help from the CDC, as well as other national organizations to put our PQC together and it's really getting started now.

The other thing that we have done, we participated in the Medicaid Innovation Accelerator Program to look at maternal morbidity, severe morbidity, with an emphasis on the cardiovascular issues because that's our biggest - when you look at the severe morbidity, that's our biggest type of morbidity is in the cardiovascular realm which is one of the reasons that a maternal cardiologist is on the review committee and, so, looking at things specific to cardiology if we can help.

And we're working with our data people from the Office of Health Data Analytics to get a better idea of how to pull that data and learn from the data that we have.

Kentucky is also one of the fifteen states awarded the SUPPORT 1003 Planning Grant. We're the only state that shows the focus on women of chid-bearing age. So, we've got this little group working within our Behavioral Health Division looking to address issues surrounding substance use

and moms.

And, then, of course, we've just applied for a couple of other things, one addressing postpartum care and what we can do about postpartum care, the other around maternal morbidity.

So, we are working on it - not thinking about it - we're working on it.

The PQC, of course, was started by Dr. Connie White. This is what grew out of our OMNI initiative. Medicaid is one of the partners on the steering committee. So, we've been a big part of that and working with this group from the beginning.

The PQC actually just finished their first year doing needs assessments from the providers and from the hospitals and we've broken up into several groups. One is I just call it a mom group and one is the baby group looking at different things that can be done and different initiatives that can be done in those areas to improve care.

And, then, the last group is really a data group. It's looking at the recommendations from that Maternal Morbidity Review Committee and seeing what we can do with that.

And I'm just looking at my little R's. I forgot to tell you. This little red

"R" is one of your recommendations. So, we looked at what you, Dr. Partin, said in the last meeting and you had a bunch of different recommendations. So, every time you see a little red "R" is a recommendation from you from the last meeting. I thought it was cute because it's an "R" and it was a recommendation.

Postpartum care. So, Medicaid did a focus study in 2018, it finished in 2018 and they're looking at long-acting reversible contraceptives and postpartum care, and we learned that 62% of our beneficiaries had a postpartum visit which means like 38% did not go to that postpartum visit which I thought was horrible.

Among the 62% of the women that went to the visit, most, but not all, 81% were screened for postpartum depression and only 44% were screened for substance use disorders. I thought that was awful low and that it needed to be increased.

But additionally at that visit, only about half of the women received any type of contraception. And of that half, which is really only, gosh, less than a third of the overall women that gave birth, only 12% received a long-acting reversible contraceptive.

And just to back it up, Medicaid covers about 27,000 births per year in Kentucky which is about half of the births that we see.

So, why is birth control important? Well, it helps to space out pregnancies and healthier moms make healthier babies. So, it's important that the mother's body recuperate, that they get higher iron levels, that they are less stressed. Spacing out those pregnancies really help.

And, so, there's lot of birth control options out there that did not exist twenty years ago. You have the implants but you also have the fancy IUD's and these are called the long-acting reversible contraceptives.

You put them in. They last three to five years and the mom doesn't have to worry about getting pregnant during that time. They are truly under-utilized and some of these can be done in the primary care office.

So, I think part of the issue is we can help to educate and train PCP's to administer those newer options, at least know that they're out there. Another thing that we can do is have those marks placed before Mom leaves the

hospital after birth.

We just looked at only 62% of moms go to the postpartum visit which is where they're getting contraception. And, so, what about the moms that don't go to that visit? So, this would help the moms and give them an option of birth control before they leave the hospital with their new baby.

Then, of course, getting moms to that visit is so, so important for a number of reasons, not only screenings but just overall health and hooking moms to resources that they need.

And, so, our MCOs, like I mentioned earlier, are doing a great job. They are providing the incentives for moms to go to those visits. And, then, of course, all of the MCOs cover the different birth control options.

You had mentioned the Certified Professional Midwives as help for access to care for our moms in the state and we think that's a great idea. I looked into it.

The midwives are now receiving a license from the Board of Nursing which is great. So far, there's been twenty midwives certified. And Medicaid, I think we pointed out, does not reimburse

for CPM's. Right now there's no provider type.

And, so, we've met with the Kentucky Birth Coalition and we've discussed this issue. Right now we're gathering more information and looking at how other states do that. This is an option for our state, so, we are, indeed, looking into this.

Another thing was removing the certificate of need for birthing centers and that's another thing that we need to get more into. Birthing centers may increase access to care for pregnant moms. A brief look showed that most of those birthing centers are in cities. They're not necessarily in rural areas.

And, so, part of the Affinity group that we applied for, we want to map the birthing hospitals and the birthing centers with our moms but also looking at it from the overlay of maternal morbidity and severe maternal mortality and get an idea of where we really should focus our efforts with this. So, we're looking into this as well.

Another thing I don't quite know what we can do about right now but it's the decriminalization of marijuana for positive moms.

We're thinking that a positive test may be a barrier to care. It also may be a barrier for going to that postpartum visit. Very good thoughts.

I know the newborn nursery that I work in, it's automatically a referral. Now, they don't seem to do much with that referral when we refer but there is a report taken on the moms when they are positive for marijuana in our nursery. So, we need to get more data on this and look more closely at that.

Representative Scott's bill on implicit bias trainings did not pass but it's an awesome idea of training not only like perinatal centers but any place that takes care of pregnant and parenting women really, I think, need to get training on implicit bias.

And I had actually thrown that in there that they also should get training on adverse childhood events. I think that that's so important to taking care of our young moms and in this population. So, even though it didn't pass, this is a recommendation and I think it's a great recommendation. We're going to keep this on our list as we move forward.

And, then, those low

birthweight babies, a lot of this that we've already talked about affecting lower birthweight babies - the prenatal care, the postpartum care - but looking at it, smoking is the biggest thing in our state that contributes to low birthweight babies and that about one in four babies born in Kentucky are born to moms that smoke.

The MCOs all have programs for quitting smoking. DPH has programs for that.

Honestly, the two things nationwide that has actually led to a decrease in smoking, one has been increasing the tax on cigarettes and the other has been legislatively increasing the age to buy cigarettes to twenty-one.

And if those two things can happen, we can address this problem easily; but until that happens, I think we need to stick with asking and referring moms to the smoking programs that we have.

The other thing that contributes to low birthweight babies is chronic stress. And, so, addressing the social determinants of health such as housing, healthy foods, transportation, those are the things that's going to help decrease the chronic stress on our mommies that

are hopefully going to lead to a healthier pregnancy and a healthier baby. So, addressing that somehow in the medical care that the moms get would be great.

And all of our MCOs also have population health management programs and those high-risk pregnancy care coordination programs that do address social determinants of health.

And I think the last thing that is kind of all-encompassing is the perinatal care coordination. As Dr. Partin stated, the local health departments no longer provider direct patient care for pregnant women, and I honestly don't think they're going to go back to that, but improving access-to-care coordination through the MCOs which they do now provide or other agencies would really help to improve access to care and theoretically the pregnancy outcomes.

And, then, that care coordination and group prenatal classes have been shown to help. For the group prenatal classes, it's more of a research theoretical thing with very small numbers. So, I think we need to get some more information on that.

I do know for our substantive pregnant women that have a substance use disorder,

that peer support is very important and it really helps to have a better pregnancy outcome. So, we're looking more into this realm and what we can do is something that we will do in the future.

So, hopefully, I addressed all of the recommendations that you brought up and to let you know what we are doing about it and what we have been doing, and I really appreciate that you gave those recommendations. It's very important.

Does anybody have any questions?

DR. GUPTA: I have a question. This is Dr. Gupta. That was a great presentation. What is the current minimum age to buy cigarettes in the State of Kentucky?

DR. THERIOT: I believe it is sixteen.

DR. GUPTA: Okay. I thought in the last year or so, wasn't there legislation to increase the tax, or am I incorrect?

DR. THERIOT: I don't know. I don't know, Jonathan, if you know.

MR. SCOTT: I do believe that the tax has increased, yes.

DR. GUPTA: I'm sorry. I didn't

hear what you said.

MR. SCOTT: I was going to say I do believe that the tax increased recently.

DR. GUPTA: Okay. And do you know if there's any kind of legislation out there to increase the minimum age?

MR. SCOTT: I haven't tracked anything this year. I haven't seen anything this year.

DR. GUPTA: Okay.

MS. EISNER: I also have a question. I'm just curious about DMS' position on taking birthing centers out of CON, whether or not there is a position already.

And I'm just not sure why it would be necessary because they're already in nonsub review. So, if there is an unmet need, they should be able to get that CON. So, do you have any comments about that?

DR. THERIOT: I do not. I don't think we have a position at this time on the CON.

DR. BOBROWSKI: I've got a question. On part of your presentation, you had mentioned the income security and I don't know what components that you all had talked about that on

there.

And I was just thinking of your role in encouraging folks. I know that years ago, there was this big push to get everybody to college, get everybody to college. Well, that doesn't realistically happen.

What was your role in the income security portion of that, I mean, with encouraging students, young people to get into the trades? I know in dentistry, we look for dental assistants or expanded duties of dental assistants, hygienists and, then, all kinds of businesses.

I see hiring signs all over the towns. So, I know people need people to help but I was just wondering what your role was in that portion of it?

DR. THERIOT: I think the main thing is to acknowledge that people need help and to take a more holistic view of seeing the patient.

And, so, if you screen and ask about income, if you ask if your household income that's coming in to your household, were you worried that you weren't going to meet the basic needs of your family? Were you worried about food or rent for the next month?

If they're under that stress, it's not good. So, yes, people need well-paying jobs but just asking those questions when their families come in, when the moms come in to the doctor is really important because then you can funnel that into resources that can help.

DR. PARTIN: I have a question and a comment. The question is, is Hepatitis C mandatory for screening?

DR. THERIOT: It is a recommended screening. Do you mean for pregnant women?

DR. PARTIN: Is it mandatory?

DR. THERIOT: It is recommended to screen.

DR. PARTIN: But not mandated?

DR. THERIOT: No.

DR. PARTIN: Okay. And, then, my comment is on the birthing centers. The problem is that there have been some nurse midwives who have wanted to establish birthing centers in more rural areas but they've not been able to obtain a certificate of need. So, that's a concern.

And coming from a rural area myself and knowing how difficult it is and how women

have to travel to get to hospitals to have their babies, I think that removing that requirement for the certificate of need is important.

I know personally of a nurse midwife who spent $75,000 of her own money trying to obtain a certificate of need and was not able to and she finally moved out of the state. So, I'd just like to add that.

This was an excellent presentation and I thank you for that. You touched on all of our questions and spoke to the recommendations and I so appreciate it.

I wonder if we could do this again maybe at our November meeting, an update on some of the things that you told us were in process to see where we are on it at that time.

DR. THERIOT: That sounds great. Thank you.

DR. PARTIN: Okay. Thank you. And, then, the next item on the agenda - does anybody have any questions? Sorry. Any more questions? Okay. Thanks.

The next item on the agenda was about the certified professional midwives and you answered that question. So, we will check that off

but I will continue to ask about that at our upcoming meetings until finally it's done. Let me make a note here.

The next item was to ask that the MAC minutes and the TAC reports and the binder materials be posted on the DMS website. I think we talked about that a little bit at the last meeting. Would that be possible, Sharley, to have that done?

COMMISSIONER LEE: I do believe that we are posting the MAC minutes after they are approved. I do believe that we are posting those on the website.

And, Sharley, do we do the TAC reports also on the website?

MS. HUGHES: Yes. Once the TAC reports and the MAC are approved at the next meeting, they are posted on the website.

DR. PARTIN: Okay. Great.

COMMISSIONER LEE: And as far as binder materials, Dr. Partin, I know that in the past, there used to be a huge volume of information that was posted and given to the members in a binder, and I think that it was good information but it was a lot of information and sometimes probably really difficult to get through and look and see exactly

what all it was telling us.

So, what I think your ask would be of the MAC is with that goal of driving health care improvements, access, quality, you saw just from the presentation that Dr. Theriot gave that we do have good information, but we want to turn that information into useable information.

So, I would ask the MAC to figure out or determine what sort of information you would like to look at that would help drive those policy decisions and make recommendations that would help us see improvements in access to care and in health outcomes.

And we have recently revised our reports for our MCOs. I think that we have about seventy-three reports that the MCOs provide to us on a routine basis.

We can give you a listing of those reports as long as they don't contain proprietary information and you can see if there's some of the MCO reports that you want to look at.

But I think that if the MAC just decided what they want, what information would be useful to you, we could go back and get that information and give it to you so you could use it to

help drive recommendations.

DR. PARTIN: Okay. Yes, we can do that. That would be really helpful. I think there was a tremendous amount of information. So, if we can narrow it down specifically. Sometimes it was helpful and sometimes at the moment it wasn't, but, then, later on something came up and I went back and looked at numbers and that kind of thing.

So, in that respect, I don't know exactly what we want to ask for, but let's all of us on the MAC kind of just think about it and, then, we can let the Commissioner know what kind of information we would like posted from the "binder" we used to get.

COMMISSIONER LEE: One place that we may be able to start and look at is - and I'm not sure you all - you all are out in the field - you know more about your respective jobs and what you see out there - but I was thinking one place that we might want to look at is maybe the Health Rankings of America or some sort of report on a national level that shows where Kentucky ranks in certain measures.

And, then, if we pick out a few that we want to make sure that we want to see improvements in, we could see what's going on in the

Cabinet right now as far as initiatives related to maybe smoking or heart disease, diabetes and what the MCOs are currently doing.

But if we look at those and see if we could pull out some long-term and short-term goals, I think that may be a place to start to look at some of our health rankings and what we think that we could actually achieve.

DR. PARTIN: Okay. I think that's a good start. So, what we can do is - and, everybody, if you want to email me with your suggestions for what you would like and, then, I will get those sent to the Commissioner in one thing rather than having it come in in drips and drabs.

COMMISSIONER LEE: Thank you.

DR. PARTIN: Okay. Then, the next item was at the last meeting, we were informed that the Medicaid missed appointment was going to go live today. So, how is that system going to work?

COMMISSIONER LEE: I have one little slide. Sharley, can you share that slide? We're kind of excited about this. I know this is something that you all have been asking for for a while is how can we track missed appointments.

So, I think that we've

devised something that's relatively easy. And for those of you who use Kyhealth.net - it disappeared there, Sharley. It was up and then it disappeared. There we go.

So, if you look at this screen shot - and can you scroll down just a little bit, Sharley, so that whole screen - there we go. That's good right there.

So, it might be a little bit small, but this is the screen where providers can go in and log missed or cancelled appointments.

So, when you go into KyHealth.net, this is your home screen and you can see right in the middle, there is a missed appointment up in that blue bar right after the PA. Where it says report missed appointments, there's missed appointments.

So, once you click on that, this screen is going to come up. Your provider number should already be populated. And when you type in a member ID, the name is going to also be self-populated. You have to do a valid ID but their name will come up.

And this top little box here is you can search. You can do a search. If you leave

it blank, in that second bottom, every individual in your organization or in your office that has had a missed or cancelled appointment will show up.

Now, to add one, all you have to do is go to that bottom box to say add missed appointment and you put your member ID in here and that's where it's going to populate a name - you see we have a fake name in there right now - and, then, you'll just check the reason, either missed or cancelled.

Then, there's a reason code. There's a drop-down box, and in that drop-down box, there's various reasons such as they didn't have child care, transportation, that sort of thing.

And you can just select one of those. And in the event that we see that this form is being used frequently and there is a reason code that's not in there, we can simply add that.

And if it's the appointment date, if they missed the appointment and it's today, then, that date would already be populated. You can put the time and you could even put an explanation if you want to. You don't really have to.

And if an individual calls to cancel an appointment, you can put a future date in

there; but if it's a missed appointment, it has to be today or maybe a previous date but it can't be a future date, but it can be a future date if it's cancelled.

All of this information will go into our system. You will be able to run reports yourself and look and see what sort of reasons and how many people are missing or cancelling appointments.

But the big win for us is that the State will also, the Department will also be able to run a report. We can run it by region, we can run it by reason code, we can run it by MCO, and we can begin outreach to these individuals and find out exactly why they're missing appointments so that we can get them in the office to ensure that they are receiving the care that they need.

So, again, this is not something that's billable. We can't pay for missed appointments, but what we can do is track and monitor and make sure that we're doing everything we can to outreach and get those members in to their appointments.

I believe it is live today and you can go back and use it. We did have a volunteer

that used the system and we didn't have any negative feedback or anything like that. So, I think that's it.

Again, the whole purpose of this is to assist us in identifying why individuals miss or cancel and outreach and trying to get them back in to the office. And, again, that goes along with a priority of improving health care for the population we serve.

DR. PARTIN: Thank you. That's great.

COMMISSIONER LEE: Do you all have questions? Again, it will only be as functional and as helpful as providers use it. So, we'll start monitoring and we can bring back reports to the MAC and see how many providers are using it, what sort of information we're seeing, and I think that will help us, too, with driving that positive policy change.

MS. EISNER: Ms. Sharley, there's one piece of business from the January meeting that's not on Old Business and it was that issue I brought forward at the very end, and I don't think I've ever spoken as quickly as I did then because we were running late, but there was a recommendation for DMS to evaluate the concern that I

brought about some IMD's not being paid by some MCOs as per Managed Medicaid 42 CFR Part 438.

And the recommendation was for DMS to evaluate the concern and work with the MCOs to understand and to get them to follow that regulation, and I don't see that on. So, can we put that back on Old Business?

MS. HUGHES: Yes. I know I requested that you send me the information but I never did get it. If you can send me that.

COMMISSIONER LEE: Nina, I think you did send me some information and I apologize if I let that fall off of my radar. I will definitely go back and look but I remember you sending specific information related to some of those pages, and I'm not sure if I have given that to staff to look at or not but I do remember receiving that.

So, we will follow up with you. We can follow up with you even outside of the MAC but we can also follow up at the next MAC.

MS. EISNER: Perfect. Thank you. And if you need anything else, just let me know. So, we'll talk.

COMMISSIONER LEE: Thank you. And I, again, apologize for letting it fall off our

radar.

DR. PARTIN: Speaking to that, Nina, and to everybody, when I send out the draft agenda, I try to make notes and I try to include everything that's Old Business; but if I left something off, all you have to do is email me and I will put it on the agenda.

MS. EISNER: Thank you.

DR. PARTIN: Sometimes it's hard for me to write everything down and listen at the same time. I'm not a very good secretary.

MS. EISNER: Not a problem. Thank you.

DR. PARTIN: And, Commissioner, you are still up.

COMMISSIONER LEE: Just a few little updates. I know we still have some of the TAC reports.

Enrollment, we currently have 1,661,305 individuals enrolled in the Medicaid Program and that's up about 340,000 since the pandemic began.

And since March, we have spent approximately $180 million, $190 million on COVID-related services. That does not include vaccinations

but it does include testing and treatment for individuals with COVID.

A personnel update for the Department. We recently hired Jennifer Dudinskie. She is our Director for Program Integrity. So, you may be seeing her name around on some documents and things like that but we were very thrilled to have Jennifer with us and working in Program Integrity.

Some other things. We do have two regulations right now that are in comment period. One of them is the physician's regulation which we made a change to include medical direction for anesthesia. So, that is still in a comment period. If you would like to review and comment, please do so before the period ends.

The other regulation is a Supports for Community Living appeals regulation. Basically, it has some information regarding waiting lists in there. Again, if you would want to go out and look at those regulations and provide comments before the comment period ends, please do so.

We still continue to look at our prior authorization process. During COVID, we're trying to be very thoughtful about when we reimplement prior authorizations. We do have prior

authorizations. We are allowing it on outpatient services right now. Still no prior authorization on inpatient services or behavioral health services, and we do have a few prior authorizations in place for medications.

And as we go forward with this and we start turning the prior authorizations back on, what we would like to do or we hope to do is kind of align as much as we can across MCOs to maybe reduce a little bit of administrative burden on the providers. So, it's something that we're definitely looking at as we go forward.

We are still on target to have our MCO single Pharmacy Benefit Manager in place by July 1st. We do have a contract with Medimpact and we are working with them to get systems in place and policies, procedures, those sorts of things for the July 1 date.

I think we talked about bills just a little bit. Of course, the ones that we know were passed and signed that we're keeping an eye on and we'll need to do a little bit work is House Bill 40 which is telehealth.

We're going to start diving into that a little bit more and developing our State

Plan Amendment so that when the public health emergency ends, that there should not be a huge disruption in the delivery of telehealth services as we see today.

Again, the copay regulation, eliminating copays for Medicaid members, we will be doing communications for both members and providers. We're very excited about that one.

House Bill 183, Steve Bechtel talked about that which was the HRIP Program.

The other thing that we're going to definitely be keeping our eye on is the American Rescue Plan. There are some provisions in there that we want to explore a little bit more in detail.

For example, the twelve-month postpartum coverage, rather than sixty days, there is a provision in the American Rescue Plan that goes along with the presentation that Dr. Theriot just gave related to how do we take care of our pregnant moms and babies.

And, currently, Medicaid has a sixty-day postpartum coverage for pregnant women. Then, after sixty days, if they don't fall into the Medicaid Expansion or other coverage category, they

lose benefits.

So, we're very interested in the ability to maybe give twelve months postpartum to those women rather than sixty days.

We're also looking at the additional federal support that was listed in there for the HCBS program. We're waiting to receive further guidance on that from CMS because the increase, it's a one-time increase and we can only use that for activities that enhance, expand or strengthen the HCBS program. We can't use that for something that is ongoing, for example. We're still looking at that.

So, those are some things that we're looking at and I'd be happy to take any questions.

DR. PARTIN: I have a question and it's in regard to United Healthcare Community-Based MCO. I had a patient report to me recently, actually two days ago that she needed dental care and she called every single dentist that was on the United Healthcare list and they all told her that they were not accepting the insurance. She did have a bad tooth that needed to be worked on.

So, we did finally get her in

with a dentist from Greensburg who was not on the list who did accept her but nobody on the list would accept her insurance. So, I just wanted to ask if DMS could check into that.

COMMISSIONER LEE: Thank you for bringing that to our attention. We will definitely look at that. What area was it in?

DR. PARTIN: Adair County.

COMMISSIONER LEE: Adair County. Okay. We will definitely look into that. Thank you so much for that information.

DR. PARTIN: She lives in Adair County.

COMMISSIONER LEE: We'll circle back with United. She called every dentist that was on the list. I don't know where all the dentists were. There are like nine pages of them.

COMMISSIONER LEE: We'll definitely follow up with that.

DR. PARTIN: Okay. Thank you. Any other questions?

MS. ROARK: Yes. This is Peggy. I also had the same problem with WellCare finding a dentist. A lot of people is not accepting it or something. So, maybe you could check on that one,

too.

COMMISSIONER LEE: We will definitely do that, Peggy. Thank you.

DR. PARTIN: Anything else? Thank you, Commissioner. As always, I appreciate you sharing so much information with us and working with us. It's just great. Thank you.

So, we will move on to our TAC reports, and first up is Behavioral Health.

DR. SCHUSTER: Good morning. Sheila Schuster here, the Chair of the Behavioral Health TAC.

Our TAC met on March 3rd and all six of our TAC members were in attendance. So, we had a quorum. We also had representatives from DMS and DBHDID. All six MCOs were represented, as well as a number of members of the behavioral health community.

An ongoing issue has been targeted case management and we so appreciate the Commissioner being present at our meeting. We had a very, very fruitful discussion about the importance of targeted case management.

And I appreciated the Commissioner challenging the TAC to come back to her

with some specific recommendations about pulling data from the DMS database that would help us know whether targeted case management is successful or not, what are the outcomes that we're looking for, who are the people that are getting it.

And we have a tiny little workgroup that Dr. Brenzel from the Department for Behavioral Health, Developmental and Intellectual Disabilities is working on with us, as well as a couple of providers who have done some research in this area.

And, Commissioner, you will be receiving a report from us in the very near future with some recommendations.

So, we appreciate your approach in using data, and we know that DMS has tons of data, and using it to really set out health policy and determine whether these services are beneficial or not, who is doing it well, what approach needs to be replicated and so forth.

We also had a new issue come up and it's one that I suspect other members of the MAC also come up against and that's the issue of billing and receiving reimbursement for those who are considered dual eligible.

So, we have a lot in the behavioral health community who have both Medicaid and, then, also Medicare because they have disability insurance. And the providers have great difficulty getting payment for services that are Medicaid services that are not provided and never have been provided by Medicare.

I understand with children, that the dual eligibles are more likely to be Medicaid and, then, some private insurance.

And, so, we appreciate that Angie Parker and Lee Guice were on our call and they've indicated that they are open to receiving specific information about cases where this has happened.

And we may be coming back at our next meeting in May to see where we are and whether there's a recommendation to be made to the MAC around this issue.

We also had a discussion about the single formulary rollout. And as I indicated at the last meeting where I was upset about the glitches, things are better. They still are not working as well as we would like, and we very much appreciated having two child psychiatrists on the

call that are still having problems with the single formulary.

So, we have again asked that people let Dr. Jessin Joseph know. He also shared with us the MCO contacts, but we want to keep the higher-ups in Medicaid in the loop around that.

Leslie Hoffmann gave us an update on the SUD services to individuals who are incarcerated which she gave with you all earlier.

We reviewed some bills that were relevant to behavioral health.

And one of the bills I might draw to your attention, Dr. Theriot, is a bill that passed the House but not the Senate. It's House Bill 294 with Representative Rachel Roberts and it would have required hospitals and birthing centers to provide information to brand new moms on postpartum depression and, then, to have the Cabinet actually display some referral information on postpartum depression.

So, you might look at that. It did not get all the way through but it's the kind of thing that we ought to be doing whether the Legislature passes it or not. So, I draw that to your attention.

I appreciated your report so much because we know there are lots of behavioral health issues as well as physical health issues that affect moms right after birth.

Then, the final piece of business was a report from Diane Shirmer from the American Association on Brian Injury, the Kentucky chapter, and they've had a group working on recommendations around the 1915(c)ABI waivers and those are seventeen recommendations broken into six areas - expanding the waiver to include all kinds of brain injury, lack of clinical expertise in the Department, building a plan of care, standardized training for providers, creating a crisis plan of care, and doing program evaluation and performance.

And, so, we have one recommendation for the MAC and that is that we are forwarding - we've attached those recommendations from the ABI workgroup regarding proposed changes to the ABI waivers, and we ask that the MAC forward those recommendations to DMS for their review, response and implementation, if indicated.

We again want to thank the Department for continuing to ban prior authorizations for mental health and substance use disorder services

and for being such active participants in our meeting.

I do want to note that the date of our next TAC meeting has been changed from May 5th to May 11th from 1:00 to 3:00. And, Sharley, we request that that change in meeting date be placed on the DMS website.

MS. HUGHES: It should be changed, Dr. Schuster. I requested that it be changed. I think it has been.

DR. SCHUSTER: Okay. Thank you. I went up there to get the MAC Zoom link but I didn't look at our TAC. So, thank you very much.

MS. HUGHES: You're welcome.

DR. SCHUSTER: I'm open to any questions that anyone might have.

DR. PARTIN: Thanks, Sheila. Children's Health.

MS. KALRA: Hi, everyone. This is Mahak Kalra with Kentucky Youth Advocates and also the Chair of the Children's Health TAC.

We met on March 10th, our first meeting in a year it seems like which we were excited to conduct because of Zoom and utilizing Zoom effectively.

We did have a quorum which, again, if you remember, last year, that was a struggle for us since a lot of our members were across the state. And, so, again, this platform has really helped us meet and talk and connect.

We spent a lot of time in our meeting reflecting on data from DMS. So, I appreciate the DMS team for providing us with an insight of what has been happening among children and their parents during this past year.

It helped us prioritize what we need to work on this upcoming year, as well as we utilize the Kentucky Kids Count Data to kind of utilize that as another tool to make sure that we're consistently just reading and making sure we know exactly what we want to focus on.

And, then, last, we also had a TAC member round robin that kind of shared the topics that their association or their organization has been concerned about and they're working to focus on.

And what that allowed us to do with all those three pieces is we kind of laid out our road map for upcoming topic discussions and what we would like to do.

One issue that came across for

our meeting was, again, we've heard it here today is really discussing dental care for children and families. We know that there are barriers and obstacles for dental care among children, and especially for the children that are ten and older.

And, so, we were discussing how do we incentivize dental providers to ensure care for the under-served community? We recommend the MAC to really look at adequately really funding or looking at really the adequate fee schedule for services.

And I would honestly defer to the Dental TAC that would know better what that fee schedule would look like and I know that's something that they discussed at their last TAC meeting.

So, again, our recommendation is we just voice support for that change, and I know the Dental TAC has recommendations that they're advocating for it but I just wanted to show support that our TAC is also looking at that as well.

And we would love for members of the Dental TAC to come and educate our Children's TAC at the next meeting which is March 12th.

And, then, as we move forward, our next TAC meeting we'll be discussing access to mental health providers and how do we address those

barriers, especially during this time, and we know that children are returning back to school with more social and emotional issues that they were probably not used to prior to the pandemic. And, so, that's another topic of discussion.

So, Sheila, we would love for members of your TAC to be a part of the conversation as well so we could unify our messaging and our recommendations.

DR. SCHUSTER: When would that meeting be, Mahak?

MS. KALRA: It is May 12th and it's at 2:00.

DR. SCHUSTER: Thank you.

MS. KALRA: And that's all that we had.

DR. PARTIN: Any questions?

DR. BOBROWSKI: Is that 2:00 Eastern Time or Central Time?

MS. KALRA: Sorry. Two o'clock Eastern Time.

DR. PARTIN: Any other questions? Thank you. Consumer Rights and Client Needs.

MS. BROWN: Hello. I'm Miranda

Brown. I'm the Vice-Chair of the Consumer TAC. Emily Beauregard had another appointment at 11:30, so, that's why I will be delivering our report.

So, we met on February 16th and we met remotely using Zoom and we did have a quorum.

We discussed a number of issues including the option to change MCOs through March 15th, presumptive eligibility, coverage options for immigrants, updates on 1915(c)waivers, accommodations for TAC and MAC members with disabilities, and the 2021 General Assembly.

First, we want to thank DMS for supporting SB 55 to eliminate Medicaid copays and other forms of cost-sharing. This is a huge victory and it removes a major barrier to care for Medicaid members. It also removes administrative burden and cost from providers which we know has historically taken away from patient care. So, we see this as a win all around.

We were also excited to see House Bill 53 pass during this Legislative Session and become law which increases the number of Consumer TAC and Behavioral TAC members and, more importantly, creates a new re-entry TAC with a seat at the table for a formerly-incarcerated individual who has direct

experience with the re-entry process.

So, we're looking forward to having another consumer-oriented TAC working to improve access to coverage and care. Having consumer representation is something we would ask other TACs to consider as well.

And in response to recommendations made during our December Consumer TAC meeting, DMS has improved upon the presumptive eligibility application in ways that reduce barriers to immigrants and we really appreciate DMS' response in this to the issues that we have raised.

During our February meeting, we also alerted DMS to an issue with the Spanish form coming up in English and we hope to have that resolved soon.

I also want to give a special thanks to Deputy Commissioner Veronica Cecil for keeping us up to date on recent changes to presumptive eligibility, in particular the extension for some individuals whose PE was set to end on March 31st. This is really important information for us to get through for our various networks.

In addition to PE, we have also discussed emergency time-limited Medicaid during

recent meetings and have requested that DMS issue guidance to providers to clarify that all COVID-19-related testing, treatment and vaccinations are covered by emergency Medicaid.

This would increase access to COVID-specific care for our high-risk population of immigrants who are not otherwise eligible for regular Medicaid which is an important step in reducing disparities related to the pandemic and lessening the risk of spreading COVID through increased testing and vaccination.

The Public Charge Rule has also been an ongoing discussion item for the Consumer TAC and an issue we were tracking closely.

While the Biden Administration recently reversed changes made under the Trump Administration that discouraged many eligible immigrants from using public benefits for themselves or their children, we know that the chilling effects will linger and that means that many families will be hesitant to seek benefits even when they're eligible for fear that something will change and could threaten their immigration status in the future.

So, for those reasons, we continue to encourage DMS and Medicaid providers to

be proactively educating Medicaid members about recent changes to the Public Charge Rule so they can make the most informed decision for themselves and their families.

Finally, we discussed House Bill 183 which was recently passed by the General Assembly and signed into law last week. This bill creates a direct Medicaid payment to hospitals based on improved quality scores which is another win/win opportunity for providers and consumers.

We hope to learn more about this program and how consumers can have input into the selection of quality measures and evaluation as it develops.

So, our recommendations from our February 16th meeting, there are two. The first one is that DMS ensure that the Medicaid PE application be available in English and Spanish in all locations, including Kynect, the DMS web page and the Governor's COVID-19 page and any other locations where the PE application is available.

And, number two, that DMS engage the Consumer TAC in selecting and monitoring quality measures for the Hospital Direct Payment Program.

The next Consumer TAC meeting will be held on April 20th at 1:30 p.m., Eastern Time.

DR. PARTIN: Thank you. Any questions? Dental TAC.

DR. BOBROWSKI: I'm here. This is Dr. Garth Bobrowski. The TAC met February 12th. I won't share it with you right now, but about a week ago, I wrote a three-page paper on the perfect dental storm and it's sad. I shared it with a couple of my staff members for thoughts.

At our TAC meetings, the last three for sure, we have been talking about access to care and the frustrations that the dental community is having particularly participating with Medicaid Programs.

Now, I wanted to share just a couple of things in my report from our last TAC meeting. The TAC voted to share - and I apologize. I was unable to get my report out until about midnight two nights ago, but part of that report is from an oral surgeon. Their office is the only office in all of Louisville that accepts any Medicaid patients.

And I'm just telling you what they're reporting to me. He also included in that

report, for example, just an extraction. It gave a list of the private insurance payment. An average Medicaid patient for an extraction across the United States is $73. In Kentucky, like Avesis and Coventry, they pay $34.20 for that service.

On our TAC, we have an oral surgeon and he related at the last TAC meeting that just his cost is $108 to provide that service, but I put that chart in my report.

The other thing that was really concerning to them was the oral surgeons and the pediatric dentists that use hospital services. I won't give you the exact numbers but when they were using the hospitals, they were reimbursed at approximately $1,600. Well, that fee of reimbursement has been recently cut to a little bit over $900.

So, the pediatric dentists and the oral surgeons are taking a major cut in their reimbursements and finances to do hospital work.

The TAC voted to pass this on to the MAC and to Commissioner Lee. So, we've sent that out.

Another thing, it speaks it in our motions, the motion to the MAC is concerning

audits and recoupments. The problem is that sometimes during an audit, they find a clerical error and all it would take is just somebody to put in a different number and it's fixed. The work was done, supplies were used, patients were seen, the treatment was done, but due to a clerical error, it showed up on an audit.

What the dentists would like to see is if upon an audit or a recoupment procedure, the motion is to bring this to the MAC and to have the corrected claim time match what the MCOs match or the state or feds match.

For instance, like Avesis, if there's a problem, they can go back two years and audit all your charts, an MCO. They usually go back two years. The state or federal situation can go back five years.

If something got, for an example, coded as a surgical extraction and it wound up that they're only going to potentially bill it out as a routine extraction which is $34.20, then, if it's a clerical error, the dentist would at least like to collect that $34.20. The way it's set up now, if it's past two years, you get zero.

Now, I did get a report back

about two or three days later after the TAC meeting that Avesis was working on that. And one of the MCOs that they deal with did have a two-year situation where you could go back and readjust your claim. So, we appreciate Avesis getting back - I mean, within two or three days, they got back with me on that situation and they spelled out each MCO that they're responsible for and what their guidelines were.

They recently adjusted that. It was about ninety days that you could do a corrected claim but they did move it up to about three hundred and sixty-five, but the dentists would like to be on the same playing field as the MCOs are. So, that's a recommendation to go before this MAC. That's one thing.

Now, another consideration that the TAC had at the last meeting was establishing a floor for the MCOs or anybody to pay. A few years ago, I was approached by one of the - I was a participating provider of one of the MCOs and they came across the board, threatening and saying, well, we're going to cut your reimbursements and I just sent them a letter. I say, if you cut my reimbursements any more, I will no longer do business with that MCO.

And to this day, they cut my reimbursements. I sent them a letter for thirty days and I'm done with it but that's what is happening to a lot of dentists. The fees are so low that it's a business out here, too. And I know Steve Bechtel reported there a while ago about the rural hospitals are struggling financially.

Well, your dental offices are struggling also. A dental office in Owensboro, a large Medicaid office, the only one in Owensboro recently had to lay off a dentist.

And another large office in the western part of the state, they just said we can't, especially after COVID, we can't work hard enough or fast enough to make ends meet.

An oral surgeon's office in Morehead, they laid off an oral surgeon because they can't make ends meet.

Anyway, going back to this Medicaid floor, and Commissioner Lee made some comments at the TAC meeting that it's a pretty cumbersome deal to go through DMS to make these changes, but, again, it was helpful that the MCOs spoke up and that they're going to take it back to each of their MCOs and see if they can establish a

floor that everybody can agree on that it can't go below. So, that is being worked on.

The other thing was the motion was discussed to bring before the TAC that the dentistry needs an across-the-board fee increase.

The children part of it did get a fee increase in 2016; but as you just heard from the Children's Health TAC from Mahak there that even with that increase, it still is not business-wise feasible to continue in a lot of situations.

And Commissioner Lee and others have stated, well, we just don't know if an across-the-board fee could be done, but I do have some specific codes that the TAC wanted me to bring before the MAC, and that is a D1110 that's an adult cleaning; D0274 is bitewing x-rays which are cavity-detecting x-rays; D7140, extraction; D0150, a comprehensive exam; D2392 is a two-surface posterior composite restoration; and a D7120 is a surgical type of extraction.

And we can go to the CDT code book for exact wording on those descriptors if you need those codes done.

And, then, that motion was amended to include at least a 50% increase in fees

for those codes, a 100% increase for the extraction and surgical code.

And as I've told you before, even with that type of an increase, a lot of that is still below cost, and this is another reason that, as a business - and I've been a Medicaid provider for over forty years, and I guess my goal was to just try to take care of people in my community.

I'm in Greensburg; and like Dr. Beth said, Adair County is eighteen or twenty miles from here.

The other concern was network adequacy, and we've already talked with Commissioner Lee and I believe through her office and some of the MCOs, the descriptors are being improved to be more accurate on who is actually providing dentistry.

A lot of dentists have just quit seeing the adults, again, due to so many frustrations that they're having and the fees are one of the major ones.

But I want to thank Commissioner Lee for the work and effort. She has had to meet with the Kentucky Dental Association and individuals and members of her staff over the years. It's greatly appreciated to at least be able to vent

and hopefully we can make some progress going forward.

What is happening out here, too, is that one of the offices in Western Kentucky, they're having to, like you said a minute ago, one person that used $75,000 of their own money, that's happening in a lot of dental offices, that they're having to go into their reserves and the reserves are getting depleted to keep the dental offices going.

A lot of the offices have limited their practices to no new Medicaid patients or no new Medicaid adult patients, and we get reports of - I mean, like, I got one here earlier this week that there's probably not a dentist in the Corbin area that's accepting any new Medicaid patients. There's only one in Somerset. I can just go on and on.

It's becoming a dental storm. And it's not that the dentists don't want to see them. It's just we've got some logistics to work out, and this is maybe something that we can work with Steve Bechtel on and the Commissioner on kind of going forward and trying to get dentists back in here.

I do know that Avesis has been

recruiting. United Healthcare has been recruiting, and I've talked with Adam Rich a few times. He's the Director for United HealthCare Dental in the State of Kentucky and I know he is working extremely hard. So, I do appreciate the efforts that the MCOs are making.

DR. PARTIN: Can I interrupt for just a second?

DR. BOBROWSKI: And I do want to say thank you - yes. Go ahead.

DR. PARTIN: We have got a whole bunch of reports that we still have to cover and we've got twenty-five minutes to do it. So, you're giving us some really good information and I appreciate that, but we'll have to give everybody else a chance to speak, too.

DR. BOBROWSKI: I'm done.

DR. PARTIN: Okay. Did you get all your recommendations in?

DR. BOBROWSKI: Yes.

DR. PARTIN: Okay. Thank you. So, we're going to need to speed things up a little bit. So, if each of the remaining TACs, if you would just give your recommendations; and, then, if there's anything that's really pertinent related to the

recommendations, go ahead and tell us that, but otherwise you're going to need to speed up, and I apologize for that.

So, next up is Nursing Home TAC.

MR. MULLER: Greetings. Hello there. It's John Muller. We did not meet but we've been kind of busy in the nursing home world, as I know you all have been as well, particularly for us. We're going to meet May 12th. So, we will meet ahead of this.

I just wanted to do a couple of things, though. House Bill 276 was a wonderful thing. It's passed and signed and that makes the temporary PCA's, what were personal care assistants, that is going to let them be certified nurse aides at the end of the pandemic. That's great for care and great for workforce.

We'd like to thank the Senate for passing Senate Bill 5 but are pretty disappointed with the House leadership to not get that bill moved over and approved. Senate Bill 5 is the COVID liability (inaudible) what I know affects all (inaudible) dollars go directly to insurance premiums.

So, that's a large disappointment and we're the only state in our surrounding border states that does not have a bill that was passed.

And, finally, just a quick word about the vaccinations. After the Thanksgiving surge, we had a daily average of 150 (inaudible) and 65 team members daily with COVID positive. We were able to begin our vaccinations December 21st. Kentucky was first and we have some business in Southwest Ohio.

(Inaudible) averages are (inaudible). So, we were just able to begin in-person visitation last week. So, we'll have a little more to report at the next MAC meeting from our TAC and thank you all.

DR. PARTIN: Thank you. Home Health.

MS. STEWART: This is Susan Stewart. We did not meet and we do not have a report. Thank you.

DR. PARTIN: Thank you. And the Hospital TAC did meet and they sent us a report. Are we going to post the TAC reports? Did we say we were going to do that?

MS. HUGHES: We post the DMS responses to recommendations on the website. We can start putting the reports out there if you want them but the Hospital TAC did not have any recommendations.

DR. PARTIN: Right. One point, though, on the report from the Hospital TAC was that they were continuing to receive denials for claims where it was saying that the patient was incarcerated when the patient was actually not incarcerated. And I'd just like to add that that is also happening in primary care.

Okay. And, Sharley, I'd like to have the TAC reports posted on the website, if we could.

Intellectual and Developmental Disabilities.

MR. CHRISTMAN: Yes. I'm Rick Christman. I'm the Chair of the IDD TAC. We met on March 1st and briefly we discussed the return to work of participants who have been vaccinated.

I know there's many daycare centers, adult daycare centers that are operating where all the staff and all the participants have been vaccinated.

Subsequent to our meeting on March 1st, the CDC has come out with revised guidelines saying that people who have been vaccinated may gather indoors. I know that that's more of an issue for the Department of Public Health, but hopefully they'll amend their current guidelines and be more consistent with the CDC.

The other thing is there was a House Resolution 55 calling for, among other things, a review of the rates for these SCL, the Michelle P. Programs. There had been a rate review done by Navigant during the last Administration. However, that's in abeyance. And, so, we hope that this new task force will come up with some better ideas.

It's particularly a problem for people who have intensive care needs. The problem is if you accept someone for service and it occurs that their support needs are just beyond what the provider can deliver but it's onto the shoulders of the provider to find another provider which, as you can imagine, it gets very, very difficult as people become more risk adverse because of this policy.

So, you have the unfortunate situation where you have many people being served by providers who have already stated they are not able

to meet their needs, and that concludes my report.

DR. PARTIN: Thank you. Nursing TAC did not meet. Optometry.

DR. COMPTON: This is Steve Compton with the Optometric TAC. We met February 4th. All of our members were there.

Our discussion centered primarily on getting credentialed with the new MCOs and the new subcontractors. There have been some issues but they have since reached out and we're confident that those issues will be taken care of.

We had no recommendations and we meet again on May 6th.

DR. PARTIN: Thank you. Pharmacy TAC.

UNKNOWN: The Pharmacy TAC did not meet. Their next meeting will be on April 14th. So, I have nothing to report and thank you.

DR. PARTIN: Thank you. Physician TAC.

DR. McINTYRE: This is Dr. William McIntyre. I'm the Vice-Chair. We have not met since January 22nd before the last MAC meeting, and our next meeting is May 21st at 10:00 a.m. Eastern Time.

DR. PARTIN: Thank you.

Podiatry.

DR. ROBERTS: The Podiatry TAC doesn't exist. I was made aware of an issue earlier in the week with paperwork being submitted to Frankfort for PA's for durable medical equipment. Apparently, there's not an online or a fax number, a website or a fax number that you can submit those directly to Medicaid and supporting documentation has to be mailed.

If we can look into that prior to the next meeting, that would be very helpful.

DR. PARTIN: Would you email me that recommendation so I can put that on our agenda for Old Business for the next meeting?

DR. ROBERTS: Certainly.

DR. PARTIN: Thanks. Primary Care.

MR. CAUDILL: Good afternoon, Madam Chairperson. I'm Mike Caudill. I'm Chair for the Primary Care TAC.

We met on March 4th and had a quorum and the next meeting will be May 6th. We did not have any recommendations for the MAC.

Some of the things we did

discuss is the wrap/crossover claim cleanup from July 1st, 2014 to June 30, 2018. It was a good discussion. Out of this and over the last several meetings, the Department is developing a workgroup to be made up of providers, KPCA's Medicare organization, DMS staff, along with Office of Application Technology Services and Gainwell Technologies.

That has been done and the first meeting is now set for April 1st. One of the things that will be taken up is that a report concerning reconciliation, how it could occur more realtime will be presented at that time per Ms. Cecil.

We did discuss with Commissioner Lee immunization questions and she took back with her what is DMS going to do for the fee-for-service administration fee and how will that work and when will it hit the systems and can providers bill for it, also how will the administration fee work in a mobile van.

That was actually raised by one of my coworkers and we presented that at Commissioner Lee's request on the 4th; and by the 9th, we already had an answer back from Commissioner Lee which is

warp speed, I think, and I'm very grateful for that authorizing the giving of vaccinations through van sites and we've been doing that and have already been at jail sites, at adult daycares, scheduled for country stores, at county jails, taking our vans out and being able to do that and we had a very candid discussion will be paid the administration fee.

We understand that at an FQHC, this will not be a PPS rate type of payment and it will require the Department to modify their payment system to be able to process the claim which is kind of up in the air but it will all relate back to that March 9th date.

The other thing that we were scheduled and didn't but it falls into what you were talking about earlier is payment for same-day visits. The presenter had a family medical crisis and wasn't able to attend.

So, that will be taken up on our May 6th meeting, but basically it's informational because same-day in primary care visits cannot be reimbursed and there is a need and there is a strong number of states around us that provides for some type of payment methodology for same-day visits for three groups. It breaks down to three groups -

primary care, behavioral health and dental.

So, we hope to be able to explore that further on our next meeting and be able to report to the MAC at its next meeting, and that's my report, ma'am.

DR. PARTIN: Thank you. And last but not least, Therapy Services.

DR. ENNIS: Good morning. Beth Ennis. I'm the Chair of the Therapy TAC. And if I disappear really quickly, it's because I've got 2% battery left. So, I apologize.

Therapy TAC met on March 9th. We met by a Zoom and did have a quorum. It feels like our own personal episode of Groundhog Day where we're working through the same issues over and over and over again with new MCOs - applying MPPR, bundling and cutting payments.

We did submit a recommendation last time about administrative burden and the suggestion for a task force. We got a response from the Commissioner and appreciate that requesting that rather than a task force, we just put together the things that we're having problems with and our suggestions.

So, we have put together a

Google doc where we are collecting all of these things and then going to come up with some recommendations specific to those problems at our next meeting which is May 11th; however, I will say that I don't know that our recommendations will go very far because it's going to mean requiring the MCOs to use or not use certain things, and we've already been told that they can't interfere with the contract process.

So, I'm not quite sure how we're going to work this out but we're going to try.

There was one other thing and I don't remember what it was and I apologize. So, I'm going to stop there. Thank you.

DR. PARTIN: Thank you. So, we've had the reports. Any comments or questions?

Would somebody like to make a motion to approve the reports and the recommendations?

MR. MULLER: So moved.

DR. HANNA: Second.

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

Any New Business? We did it

with ten minutes to spare. Thank you, everybody.

And, Dr. Bobrowski, I'm sorry. I didn't mean to cut you off but I knew we were running out of time and I wanted to give everybody an opportunity to speak. So, I'm sorry if I seemed like I was cutting you off because your points are well-taken and important. I think all the providers are dealing with those issues. So, thank you for that.

Does anybody want to make a motion to adjourn?

DR. SCHUSTER: Will Dr. Theriot's Powerpoint be available on the website because it was excellent?

MS. HUGHES: Yes, it will.

DR. SCHUSTER: Thank you.

DR. PARTIN: It was excellent.

MS. EISNER: I'll move to adjourn.

MS. ROARK: Second.

DR. PARTIN: Discussion? So moved. Thank you, everybody.

MEETING ADJOURNED