May 27, 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
Teresa Aldridge
John Dadds
COUNCIL MEMBERS PRESENT
1. Call to order ........................................ 5

2. Roll Call ........................................... 5

3. Approval of minutes from the March meeting . 5

4. Old Business
   A. A request was made at the March meeting for suggestions on information to be posted on the DMS website. Here are some suggestions: ...................... 5 - 11
      1) Provider availability and type of provider for each MCO in each region.
      2) Kentucky ranking for heart disease, diabetes, cancer, COPD, SUD, and maternal/child health
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   C. Follow-up on request from the Hospital TAC regarding some IMD’s not being paid by some MCOs as per Managed Medicaid 42 CFR Part 438 ......................... 20 - 22
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   F. 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.......................... 24
G. The Behavioral Health TAC submitted recommendations from the Acquired Brain Injury Work Group regarding proposed changes to the ABI Waivers to the MAC with the recommendation that the report and recommendations be forwarded to DMS for their review, response, and implementation, if indicated. Could we have a response from DMS regarding this recommendation? ............................. 24 - 31

H. Follow-up (update) to the report on maternal/infant health at the November MAC meeting.............................. 31 - 33

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7. Reports and Recommendations from TACs
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   * Children’s Health ....................... (No report)
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8. New Business
   A. Judge Phillip Shepherd, Franklin Circuit Court, ruled in late April that the bidding process (the second one) for awarding the MCO contracts was flawed and must be rebid. What are the immediate and long-term effects of the Judge’s ruling that the MCO contracts must be rebid? How does DMS plan to proceed? ............ 84 - 85
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B. The MAC meetings are recorded. So that stakeholders who are not able to attend the meeting may stay informed, would it be possible to post the recording of the meeting shortly after it is held? ...... 85 - 86

C. Other ................................. 86 - 87

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MS. HUGHES: As a quick count, I think you do have a quorum but I know you all do a roll call.

DR. PARTIN: Okay. If we’re ready to get started, let’s go ahead and do roll call.

(ROLL CALL)

MS. ALDRIDGE: That’s the roll call, Dr. Partin, and we do have a quorum.

MS. HUGHES: Can you all see the agenda now?

DR. PARTIN: Yes. Next up on the agenda is approval of minutes. Would somebody like to make a motion?

DR. HANNA: Motion to approve.

DR. COMPTON: I’ll second.

Steve Compton.

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

So, under Old Business, at the last meeting, a request was made for suggestions on information to be posted on the DMS website and here are some suggestions that I had. And if anybody else has any other suggestions, please speak up.
First is provider availability and type of provider for each MCO in each region, and Kentucky ranking for heart disease, diabetes, cancer, COPD, substance abuse disorder and maternal/child health.

Does anybody have any other things that they would like to see posted on the website?

DR. GUPTA: Dr. Partin, this is Dr. Gupta. I just have a question about the provider availability part.

So, that would be what the MCOs have listed as doctors or providers accepting that insurance, correct?

DR. PARTIN: I’m sorry. My connection isn’t very good, I don’t think. I’m breaking up.

DR. GUPTA: I just wanted to confirm---

DR. PARTIN: I heard part of what you’re saying.

DR. GUPTA: Can you hear me?

DR. PARTIN: Yes.

DR. GUPTA: Okay. I just wanted to confirm that that would mean that the providers
listed under that MCO would be accepting that insurance, would be able to see those patients. That’s the thought behind that, correct?

DR. PARTIN: The thought behind it is that all the providers in the region for the MCO would be listed. So, for instance, under Ophthalmology, it would show all of the provider availability for each region that would be available.

DR. GUPTA: Okay. I just remember like maybe it was the last meeting or some of these past meetings, I think more so maybe in dentistry, that that’s not always the case, that maybe it will show up under the MCO as a particular dentist accepting that; but when the patients actually try to reach out to that dentist, they don’t accept it.

DR. PARTIN: Correct. So, if the providers are listed, then, I think there might be a better idea for providers when we’re making referrals and also for DMS when there are providers listed who then are not participating. It might be easier to detect that.

DR. GUPTA: Right. I think it just all comes down to the basic issue of reimbursement, but, anyways, I just want to say that.

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It might be a little bit misleading but I don’t know really how to address that.

DR. PARTIN: I don’t think we can address that through this.

DR. GUPTA: Right.

DR. PARTIN: But I think that it’s helpful to know, for instance, from my perspective, when I’m trying to refer a patient, it’s helpful to know what options are available for referrals.

And, also, in making those referrals, we always call to schedule the appointment for the patient and, therefore, we would know if that particular provider is listed. And the MCOs are required to have a certain number of providers in each type of specialty available for the participants.

And, so, if MCOs’ listings are not accurate, I think DMS needs to know that.

MS. EISNER: This is Nina, just to bridge on that discussion. It would seem to me that on some regular and periodic basis, there should be a requirement that the MCOs verify access is still available from that provider.

And I would assume that’s done
through the recredentialing process but I’m not sure
how often that happens, but we’ve experienced here as
well in terms of patient follow-up from my hospital
that sometimes folks who are listed under an MCO are
actually not accepting any more patients or just at
capacity or a reduced capacity and so on.

So, I don’t know what the
answer to that is but I would think that the
recredentialing should verify that availability. If
we can just verify that.

DR. PARTIN: And I would agree.

MS. EISNER: Thank you.

COMMISSIONER LEE: This is Lisa.

I’m sorry. I was just a little bit late.

The suggestion, I think, is
just to have some sort of either a searchable
database so that you could find out which providers
are in maybe a specific county and which provider
types and if they are enrolled in a specific MCO.

And I think that that could
possibly be configured. I believe at one time, many
years ago we did have a listing of Medicaid providers
by county.

Updating that shouldn’t be an
issue now with the improvements in technology, but we
can go back definitely and look at this and see if we
could get some sort of a searchable database. I
think it does then become are they taking new
Medicaid members.

I’m not sure how we could get
that information without doing a provider survey or
something like that, but definitely it’s a start and
I think getting the information on the web page would
be the start to trying to figure out how accurate
that information is and, then, we could drill down
into it later on.

MS. EISNER: Thank you. That
would be so helpful. Appreciate it.

DR. PARTIN: And that was kind
of my thought because that information used to be
available to us in the big super binders that we
received.

And, so, I thought that since
it was available in the binders, it would be
available to post.

MS. HUGHES: Dr. Partin, I know
when you had those - I mean, and I think we still
brought some reports on network adequacy and that was
the reports that we put in the binders, not
necessarily a searchable database, I mean, not a list
of every provider that they had in their network. It was more like an Excel spreadsheet that provided some reports based upon the type of provider and what percentage of the network adequacy they were meeting.

Is that what you’re talking about because the MCOs do have searchable provider directories on their websites; but when you mentioned the binder, I thought maybe you were actually looking for the network adequacy reports.

DR. PARTIN: Well, actually both, Sharley. I thought that could be combined. We did have that adequacy in the binders, but I was also looking for the actual providers and, then, providers could help DMS as far as the accuracy of those listings that each MCO has.

COMMISSIONER LEE: And I think the issue now, even though the MCOs do have searchable databases on their website, in looking for a specialty, the provider would have to go to each and every website rather than have one listed area to find that information.

DR. PARTIN: Right. Okay.

Anything else?

Then, moving along, the next item is missed appointments. Is the new site being
used and also could a notice be sent out to providers regarding the availability of reporting no shows?

COMMISSIONER LEE: The missed appointment, it’s a screen and Kyhealth.net is active. It is working. We have had forty distinct providers use that platform to report 610 missed appointments. So, providers are using it. We think that’s a great thing.

Again, the whole reason for the missed appointments, we would really like to look at that information and track by region, by area, by reason why they missed the appointment so that we can actually do some outreach and follow up with those individuals to make sure that we are doing everything we can to get them to their doctors’ appointments and so they can receive health care.

So, I’m not sure if we need to do more training or what we can do to get more providers to take that up because, again, we’re only going to be as successful as the number of providers that use that, and that needs to increase a little bit for us to get a bigger picture statewide, but definitely providers are using it. As I state, forty providers have that software.

DR. PARTIN: I had talked to a
few people and they weren’t aware of the ability to
do that. And, so, that’s why I was asking if maybe a
notice could be sent out so that people could become
more aware of that site.

DR. GUPTA: Sharley, this is Dr. Gupta again. Like, for example, in my practice, if
it were not for me, our practice would not know about
it. Maybe like posting it through like the different
medical societies or like the Kentucky Medical
Association, the local medical societies.

I think that would be really
helpful because then it can be sent to all the
providers along with maybe a mailing as well but I
think just getting it sent out electronically would
be really helpful.

DR. BOBROWSKI: I’ve got a
question. This is Garth Bobrowski. At what point
does DMS say that on these failed appointments for a
patient that enough is enough?

Dental offices have their own
guidelines and rules based on what the dentist will
tolerate. Some will, if you miss one appointment,
you’re out of luck. Some are three strikes and
you’re out.

This morning, I’ve already had
two this morning that just didn’t even show up; and
one of them, I looked back on her chart and, well,
she’s missed the last three appointments. It’s like,
well, when is enough is enough?

And when they do come and when
they call, we talk to them about these missed
appointments but it just falls on deaf ears so many
times. Just a comment.

COMMISSIONER LEE: Thank you for
those comments, Dr. Bobrowski. I think our role is
to make sure that individuals receive treatment. And
if they are not making their appointments, I think
this missed appointment tab or whatever on the
Kyhealth.net page is one way to help us identify
those individuals and outreach to them, find out what
underlying conditions may exist that prevent them
from going to their appointments and just kind of
helping them navigate a little more.

We won’t say enough is enough
because we can’t do that. Our role is to definitely
make sure that they get their medical services.

DR. GUPTA: I’m sorry. I have
one more comment on that.

I’m a pediatric ophthalmologist
and the University of Louisville is losing their
pediatric ophthalmologist and that leaves four
pediatric ophthalmologists left in the whole city and
four years ago, we had eight.

So, most of those children are
Medicaid patients. Like, our practice policy is if a
Medicaid patient has two no shows, they’re dismissed
from the practice because we just can’t - we’re a
private practice and we can’t survive on that.

So, I just worry about all
these kids, like, where are they going to go? The
only other pediatric ophthalmologists are in
Lexington.

So, this is a really serious
problem with these no-show appointments. And, again,
I think it all boils down - and this is not the place
for this discussion, I know - but is reimbursement of
the Medicaid patients and how much loss a practice
takes by, first of all, seeing these patients and
also having them not show up to a visit. I just
wanted to make that comment.

DR. THERIOT: This is Dr.
Theriot. We do also have a Medicaid practice and
we’re actually very lenient, and I think it’s just
because it’s usually not the child’s fault that
they’re late or that they missed the appointment.
And I really feel strongly that when we dismiss patients, we would be punishing the child for the parents’ actions or inactions. And, so, it’s a tough situation but we usually don’t fire our patients.

COMMISSIONER LEE: Thank you for those comments, Dr. Theriot. I think that the role of the Medicaid Program is to serve a very vulnerable population. The individuals that we serve, we have aged, blind, disabled, children.

And the only way that we’re going to make headway into those missed appointments is to start tracking them and outreach because there could be extenuating circumstances – transportation, all kinds of different things that could impact this population from getting to their appointments.

And I think that the more education we can do, the better, but I don’t think it – I would like to do more of the targeted outreach and information rather than a broad blanket, sending out letters to every Medicaid member about missed appointments.

I think that that’s the point of the missed appointment tracking is to identify those individuals and intervene so that providers can
receive their payments, so that there are reduced no-show visits.

That’s the only way we’re going to be able to intervene is on that very specific person-by-person level to kind of find out what their circumstances are and help them get in.

And I do agree with Dr. Theriot that children, they can’t drive themselves, for example, to the doctor. And I think that the overarching goal of the Medicaid Program is to definitely build a healthier population, and the way we do that is going to be, I think, targeted interventions when we can identify those individuals who need our services.

DR. PARTIN: Thank you for all the comments. And, Commissioner, that’s exactly the kind of thing that I’m looking for as far as my practice goes. We don’t dismiss patients either for no shows.

In a rural area, we find that transportation is a big problem and people don’t have reliable transportation or, in the Medicaid population, they either don’t have a vehicle or they have a poorly-run vehicle. So, a lot of times, it’s because their vehicle broke down or because they
couldn’t find somebody to bring them.

And another thing that we find is that some people who don’t have a vehicle have to pay somebody to bring them to their appointment and sometimes they just can’t afford it.

And I find it kind of sad because these are friends supposedly of these people and they charge them five or ten dollars to drive them to their appointment, and sometimes they just don’t have that five or ten dollars to get there.

COMMISSIONER LEE: These are----

So, I think - go ahead. I’m sorry.

COMMISSIONER LEE: I’m sorry. I said these are the kinds of issues that when we hear about them, it is heartbreaking because we have a non-emergency medical transportation program that should be taking individuals to their appointments.

So, again, I mean, why do the individuals not know about the services or are they just being denied because they have that poorly-functioning vehicle in the household? It’s definitely something that we’re looking into right now.

We do know, for example, in 2020, the
number one reason that individuals were denied non-emergency transportation is because they did have a vehicle in the household but sometimes that vehicle may not be running. They may not have gas money for that vehicle.

So, trying to drive down again into those missed appointments, the more information that we do have, the better we can maybe change a policy or transportation policy concerning the vehicle in the household.

But we provide millions of trips each year, and I think digging down into that information may give us some insights, too, as to why or where individuals are not receiving that transportation.

DR. PARTIN: You hit it exactly the nail on the head. A lot of people do have a vehicle but it's poorly functioning or not functioning at all.

But a lot of them, you know, I'll say your car isn't working, and if it hasn't worked in a year, maybe you should sell it. And they're like, no, I can't sell that car. My kids might need it or something like that.

I think it's sometimes just a
matter of pride just to have that vehicle even though
it’s not running, but, anyways, I guess we’re
belaboring the point but lots of reasons.

MS. EISNER: If I may just one
more, please. I understand all the transportation
challenges and I think that there are real gaps in
terms of the non-emergency transportation.

But I just want to say that the
problem is bigger than transportation because at
least in the behavioral health world, at my hospital,
we have continued vast telehealth services.

So, individuals don’t have to
drive to get that follow-up care that’s so critical
and critical to the managed Medicaid company, too,
because they have that NCQA criteria to meet, and we
have as many problems with telehealth as we do in-
person appointments.

So, I’m just saying, that’s
why, again, telehealth, the continuation of some of
the telehealth regulation changes during the pandemic
are critical but it doesn’t get rid of this problem.

DR. PARTIN: It’s many-faceted,
for sure. It’s not just one thing.

Next on the agenda is a follow-
up on the request from the Hospital TAC regarding
IMDs not being paid by some MCOs per Managed Care Medicaid 42 CFR Part 438. And, Nina, I think that was your issue.

MS. EISNER: It is. And this has been going on now for months, as you all know. You’ve heard me bring it up. The TAC has brought it back as well.

There have been discussions. We have sent and re-sent the information to the MCO that doesn’t pay for emergency services, and obviously there are two issues.

There’s do they contract with the IMD, and do they pay for the emergency care that’s provided which does fall under 42 CFR Part 438? And I will say that on both fronts, there is not a solution yet.

What we’re talking about in terms of access, just in the Louisville market, that’s 388 beds that are not able to be accessed on any regular basis by individuals who fall within that IMD category under Managed Medicaid.

So, it’s got to stay on the list until it’s resolved and it still isn’t. Thank you.

COMMISSIONER LEE: Thank you,
Nina. I think I have seen some information related to this topic. I haven’t taken a deep dive into that information yet but we will continue to work on this.

DR. PARTIN: So, Nina, do we need to keep this on the agenda for our next meeting?

MS. EISNER: Yes, please.

DR. PARTIN: Okay. Next up, our podiatry representative noted the paperwork for PA’s for durable medical equipment must be mailed. Is there a website or a fax number where these PA’s may be submitted? That was at the last meeting.

DR. ROBERTS: So, Lee reached out to me. I think the issue was it wasn’t the original PA. It was the supply and supporting documentation.

And there was a fax number which was one that we had originally tried but the fax number was having technical issues I guess over that week. And, so, they had provided an alternate fax number that was also having issues.

When our DME staff actually snail-mailed the supporting documentation in, the PA was corrected.

And I had asked her if this had come up in the past or this was kind of a one-off
thing, and she said she had the same issues before, but it may have just been a technical issue on their end at that moment in time.

So, there is a system in place to prevent that but it may have just been technical issues.

DR. PARTIN: Okay. So, you’re okay now? There’s not a problem?

DR. ROBERTS: Yes. I think we can mark it as resolved. If it continues to be an issue, we’ll follow up to see on a technical side, on the fax technology side, if there’s an issue that needs to be corrected on the other side; but I think for the MAC’s purposes, this can be checked off.

DR. PARTIN: Okay. Thank you.

The next item, has any work been done to amend the Medicaid regulation to reimburse Certified Professional Midwives?

COMMISSIONER LEE: We have not opened that regulation yet. It is on our radar but we have not amended that regulation yet.

DR. PARTIN: Do you think that that’s something that’s going to be coming in the future?

COMMISSIONER LEE: We’re still -23-
considering it, and right now, we’re focusing on other projects, other priorities, but we definitely are looking at it.

DR. PARTIN: Okay. Then, I will keep that on the agenda for next meeting.

Okay. The next item is again request amendment to the Rural Health Clinic regulation 907 KAR 1:082, Section 9(1)(b)2 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, and three days would be in line with other regulations and more realistic for busy clinic settings. Where are we in that?

COMMISSIONER LEE: We do plan on aligning those time frames. Again, it’s on our list to do but we haven’t gotten to that yet.

DR. PARTIN: Okay. I’ll put it on for the next meeting.

The next item may have been addressed because we got the responses late and we hadn’t had responses from the TACs when I did the agenda.

So, that had to do with the
Acquired Brain Injury Workgroup proposed changes, and DMS provided an extensive response to that recommendation.

So, I’ll leave that off until the TAC gives their report and they can let us know if that response was satisfactory.

COMMISSIONER LEE: So, what we’re talking about the recommendations, I don’t know if it’s COVID or I think that there’s been a little bit of a slack I think in the formal process because I had to address this at the MOAC last week or so before, so, I’ll speak to it again.

But I think that we need a process and what I was thinking is maybe if the TACs would submit their recommendations to Sharley at least two weeks or so prior to this meeting and, then, we could compile all of those recommendations, get them to the MAC at least a week before the meeting so that you all have time to digest them and, then, could actually do a vote on the recommendations that you would like to put forth.

I think sometimes - I know that the TACs do give their presentations to the MAC and they fold their recommendations into it. And, so, we just get the blanket recommendations, and I would
like to see that get back to like more of a formal process where we get the recommendations and, then, make sure that we respond back to them, the Department, and what we would do is respond back to the MAC and, then, copy the TACs so that we keep everybody in the loop and everybody on the same page as far as the recommendations are concerned and our response to those recommendations.

DR. PARTIN: Okay. Let me make sure I’m understanding what you’re saying.

The recommendations from the TAC are given at the meeting. And, then, generally what the process has been is within thirty days after that recommendation is made which is halfway between when the next MAC meeting would occur, that’s when we used to get the responses.

So, I guess I’m not understanding. Do you want the TACs - the TACs can’t submit their recommendations before they meet.

COMMISSIONER LEE: Right. So, I think we need some sort of a process. I was under the impression that the MAC would get the recommendations and vote on which ones they wanted to push forward rather than every single recommendation coming forth.
So, I’m under the impression that once the TACs meet, then, they can form their recommendations to push up to the MAC and we, the Department, would compile every one of those recommendations and give them to the MAC for consideration rather than pushing every one of them.

I mean, if you want to just consider every single recommendation they make, but I think the formal process is the TAC makes the recommendation. They submit it to the MAC and, then, the MAC would vote on which recommendations they want to put forth and, then, the Department would respond to those recommendations.

DR. PARTIN: Okay. And, generally, the MAC has accepted all the recommendations that the TACs have made unless there’s some resolution that occurs at the MAC meeting itself.

COMMISSIONER LEE: And those recommendations, we would not be making a - when the TACs send them to us, we would not be making that - we would compile all recommendations to send to the MAC from one comprehensive document for the MAC to consider.

And, then, those
recommendations would come back to the Department, the ones that the MAC wants to push up would come back to the Department for a review and response.

DR. PARTIN: Okay. So, the process is basically the same, that the Department will respond within thirty days to the recommendations. Okay.

COMMISSIONER LEE: Yes, and thirty days of the MAC giving them which is we would respond within thirty days, yes.

DR. PARTIN: Okay.

MS. HUGHES: I’m sorry. Just to clarify because there’s a comment in the Chat. Yes, no recommendations can come forward before the TAC actually meets.

And I think what we’re just trying to do is get the - I got recommendations this morning from a couple of the TACs and that doesn’t give me time to get the information out to the MAC members for you all to review prior to your MAC meeting. But, Beth Ennis, yes, the TAC has to approve the recommendations.

And just as another point of clarification, we usually have forty-five days to respond to any recommendations. That’s what is in
the bylaws.

COMMISSIONER LEE: What we’re trying to do and the purpose is to get that formalized process in place because there was, for example, the Pharmacy TAC I think in November came to the MAC and they did read off their recommendations, and the Department did not formally respond.

So, it appears that we didn’t review those recommendations but we did but we didn’t have that formal response back.

So, what we’re trying to do is just get a very formal outline structure so that all recommendations are presented to the MAC. The MAC votes on which recommendations they want to submit to the Department. The Department reads, reviews, considers and then responds, and we want that all to be documented and formalized, so, going forward, that the TACs and the MAC know that we are definitely looking at their recommendations and that they’re being voted on.

DR. PARTIN: Okay.

MS. ASHBAUGH: This is Cindy Ashbaugh and I’m trying to take the minutes. So, for this line item, I want to make sure that I’m clear.

So, the deliverable is that the
recommendations are given to the TAC. The TAC will then send them to MAC. MAC will review, send their responses to DMS and, then----

COMMISSIONER LEE: What we will do is the Department will develop some written guidance to send out to all the TACs and the MAC.

MS. ASHBAUGH: Okay.

COMMISSIONER LEE: That will be the action item here. We’ll do that and, then, everybody will be on the same page going forward.

MS. ASHBAUGH: Okay. Perfect.

MS. HUGHES: Ms. Ashbaugh, who are you taking minutes for?

MS. ASHBAUGH: Just for - I’m sorry. Just for Passport by Molina.

MS. HUGHES: Okay. All right. I thought you meant official records. Okay. Thank you.

MS. ASHBAUGH: Oh, no, ma’am.

MS. EISNER: And just to clarify again. Only recommendations from the MAC will go to DMS, not discussions or anything like that. It has to be a formal recommendation from the MAC.

COMMISSIONER LEE: Yes.

MS. EISNER: Thank you.
DR. PARTIN: The only thing that I would ask as this is formalized is that I have to provide a draft of the agenda two weeks before the MAC meeting.

So, if I could have the recommendations from DMS at least a couple of days before I have to do the agenda, that would be helpful because sometimes the TACs want me to bring forward the issue again if they don’t feel like the response is adequate, so, just to give me time to read it.

COMMISSIONER LEE: We’ll outline time frames and things in the directions.

DR. PARTIN: Okay. Great.

Thank you.

And, then, the next item on the agenda is just actually to help keep me reminded that we’re going to have an update on the report for the maternal/infant health at our November MAC meeting.

So, there’s no action on that. It was just a reminder, and I’ll keep that on the agenda just to help me stay reminded that that’s what we’re going to do.

COMMISSIONER LEE: Dr. Theriot is participating in the meeting. I’m not sure if she has an update at this time.
DR. THERIOT: We have been working with our sister agencies as well as non-profits on maternal and infant health. We’ve continued to work with the nurse midwives to really look more at the midwife model of care and what they can provide for the state.

And we’re really looking (inaudible) were accepted for the Affinity Group, the CMS Affinity Group and we’ve chosen to really look at that with an equity lens, and most of our maternal deaths are after the baby is born. A lot of our moms don’t go to the postpartum visit and obviously a lot have - more than 50% have substance use related to that death.

And, so, we are trying to look at that population to see what is needed and what can be done on a state level to improve the care.

So, we are working on it and hopefully I’ll have some good stuff to report later on.

DR. PARTIN: Great. Thank you. Again, that report was so excellent and just really appreciate it.

So, like I said, this is just a - I didn’t even expect you to give any update today.
It’s just a reminder to met to keep it for the
November meeting.

Okay. Next up is the
Commissioner.

COMMISSIONER LEE: On the 20th
of May, I did give an update to the Medicaid
Oversight and Advisory Committee. Dr. Partin was
also there and gave an update. Thank you, Dr.
Partin, for your update.

Basically, I went over some of
the impact of COVID on the Medicaid Program, and
nationwide we have seen growth in the Medicaid
Program. Kentucky was third in the number of
individuals who enrolled and the increase in
Medicaid.

We have enrolled I think about
300,000 new individuals in the program since the
pandemic began. We did see an increase in child
enrollment as well. We saw 52,000 individuals, new
children enrolled in the program.

We think that’s important to
note that there are children in the program because
we’ve also been noticing, for example, that the
preventive services have decreased a little bit. So,
we’re concerned about children who didn’t receive
their well-child check or who may not have received
the full array of services in their well-child check
and what that means for our future costs related to
serving the population.

We do notice that the well
visits aren’t on the increase. They are not to pre-
COVID levels yet but they are increasing which is a
good sign.

We do know that the increase in
enrollment was the result of changes in the economy.
Individuals who had income loss or job loss
definitely turned to the program in a time of need.
The majority of the individuals were in the Medicaid
Expansion population which is between the ages of 18
and 65.

So, we also currently, just a
reminder, that the ACA has a special open enrollment
period that runs through August 15th of 2021, and
the----

(INTERRUPTION)

COMMISSIONER LEE: Is everybody
else hearing the recording in progress and recording
stopped?

DR. PARTIN: Yes.

MS. HUGHES: Sorry.

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COMMISSIONER LEE: So, back to the information that I presented to the MAC.

Again, the ACA has open enrollment through August 15th, 2021 with reduced premiums for individuals who qualify for a product on the Exchange. So, if individuals have lost their health insurance, they can go ahead and apply for a product on this Exchange so that they remain covered.

We have been monitoring the pre- and post-COVID expenditures by provider type just to monitor the impact it’s having on our provider community. We have been monitoring that both by fee-for-service and MCO.

One particular thing that we’re definitely keeping an eye on is our ER utilization. We have noticed a drop in both emergent and non-emergent ER utilization post-COVID.

We’d like to examine the trends prior to the public health emergency to see what we can identify and compare it to the utilization now to see if there are any interventions that we could identify that may help keep non-emergent use of the ER in check because we definitely want individuals to receive services in the appropriate location at the appropriate time.
We have noticed a lot of increase in telehealth use. That trend is still continuing. Even though we are a year and a half almost into the pandemic, we are still seeing utilization of telehealth services.

We had 18,839 distinct fee-for-service members - those are members who are in Home- and Community-Based Waivers and long-term-care facilities - diagnosed with COVID.

We have noticed that the amount per claim for these individuals was definitely higher at the beginning of the pandemic; but as we learned more about COVID, I believe that the cost of the treatment is coming down somewhat.

In our Managed Care arena, we had, that we can identify, 47,188 distinct members who had been diagnosed with COVID.

At the Medicaid Oversight and Advisory Committee meeting, I also talked a little bit about some of the legislation that we’re implementing, and I talked just a little bit about Managed Care Directed Payment Programs.

So, anytime the Department mandates or directs the Managed Care Organizations to pay a particular provider group a set dollar amount,
that’s considered a directed payment and CMS requires that we submit a preprint, not a State Plan Amendment, but a preprint, and in that preprint, we have to identify quality measures.

What exactly is that enhanced payment or that set payment amount point-of-view for the Medicaid population? Is it going to increase quality to care? Are we going to have better access? So, we have to identify those types of quality measures for CMS to approve that program.

So, you all know that one of the biggest pieces of legislation that we have been working very hard to implement is Senate Bill 50 which requires the State to use a single MCO PBM.

We have contracted with Medimpact and Dr. Fatima Ali and Senior Deputy Commissioner Veronica Judy Cecil and Angie Parker, the Division Director for Program Quality and Outcomes, have been working very hard to implement that single PBM come July 1st.

They’ve been holding routine meetings, been talking about benefit design, things like that. They’re updating the reimbursement methodology that’s going to align with our fee-for-service program.
We are providing a $10.64 dispensing fee and we are aligning the Formulary across all MCOs. We are working on a process for prior authorizations to ensure that no individual loses or has a disruption in care for their medication.

We definitely have engaged the MCOs. They have been at the table to assist and they’re working very diligently and collaboratively with us to implement Senate Bill 50.

We had some webinars for providers and we definitely are, again, working to make sure that no member has a disruption in service come July 1st when we fully implement the single PBM.

And providers will receive their payment - if they have an electronic funds transfer information on file with Medicaid, then, that’s how their payment will be made, but if they do use a PSAO and that PSAO is on file as the payee, the payment will go their PSAO.

We definitely want to look at how Senate Bill 50 and the single PBM impacts the Medicaid Program. So, we’re looking at certain data sets, what do we need to look at to see the true impact of this legislation on our program.
We also are working on House Bill 183, the Hospital Rate Improvement Program. We have received approval from CMS for one year. We have recently submitted another preprint to them for a three-year time frame.

We are working on and are very excited actually about House Joint Resolution 57. This requires the Cabinet to establish a workgroup to assess the feasibility of implementing a Bridge Insurance Program.

So, what that would mean for the Department and for the State is a Bridge Insurance Plan would cover individuals who don’t qualify for Medicaid but yet can’t afford a premium on the Exchange. It’s kind of like a gap insurance coverage to make sure there’s a full continuum of affordable insurance for individuals in Kentucky.

That workgroup is scheduled to meet in July, the first meeting, and it’s a short-term workgroup and it goes up to December 31st with a report given to the Governor and the Interim Joint Committee on Health and Welfare.

Also, the 1115 Waiver is still pending. The (inaudible) for incarcerated individuals is still pending.
And I think with that, I will stop. I’ll take a breath and see if anybody has any questions.

MS. EISNER: I do. Sorry. It seems like I’m talking all the time. Two things, please.

One of the things that the behavioral health providers throughout the state have really benefitted from during the pandemic was the MCOs not requiring a preauthorization, rather a notification. Continuing care authorization was not required and discharge is only a communication.

With all of the dire elements from the pandemic with the increase in suicides and substance use disorders and overdoses and all of that, do you believe that the Cabinet will - and we really appreciated not having the authorization required for BH.

Commissioner, do you see that as something that will be continuing?

COMMISSIONER LEE: Nina, as you just said, there is definitely a lot of focus on behavioral health right now.

We have authorized the MCOs to implement prior authorizations on services except for
behavioral health and substance use disorder treatment services at the current time. So, the behavioral health and substance use disorder treatment currently are not - currently no prior authorization, but I think that we need to actually take this time instead of going back to the way we did things before and we can really look at the services. Is there some way to modify the prior authorization process or really do a deep dive into it to see what makes sense going forward?

But at this time, we do not have a prior authorization on behavioral health and substance use disorder. I do think it’s an opportunity for us to dig into some of those services and see what makes sense going forward.

MS. EISNER: I really appreciate that.

And one other question. You were talking about Senate Bill 50 and the requirement for a single PBM and so on.

It’s my understanding that Senate Bill 50 does not discriminate in any way under 340(b). Is that correct?

COMMISSIONER LEE: That is correct. There was a little bit of confusion I think
at first, that we were going to apply some of the lesser-than logic that we do in the fee-for-service to a 340(b) but we are implementing in compliance with Senate Bill 50.

MS. EISNER: Thank you very much.

MR. POOLE: This is Ron Poole and I have a few questions. I’m Chairman of the Pharmacy Technical Advisory Committee in case anybody wanted to know.

I’ve got two topics, both totally different topics to speak of. First of all, on the pricing methodology, Senate Bill 50 was passed and signed March 27th of 2020.

And it being done in other states this way and it has saved money in other states, I don’t know if the design that we have in our state is geared to the savings that we’re seeing in other states. I certainly hope so.

And certainly I’ve had it explained to me by Jessin and others and yourself of why it has taken this long to actually implement.

So, I’d like, first of all, a comment on the time period there, why it was required, but, secondly, here we are. Pharmacists
are really struggling in the state, pharmacy owners. And effective January 1st, CVS Caremark was granted a reduction of twenty cents in their already-abysmal dispensing fee of $2.35 to $2.15.

And just in my pharmacy alone for the first six months of this year, my pharmacies, my company, that’s $5,500 off of my back that’s coming out. So, you multiply that if you have a good wide range of busy and slower pharmacies. And, so, I would think I would average out to be the normal pharmacies in the state.

So, you multiply that times 1,100 pharmacies in the state and you’ve got a windfall for CVS Caremark of $6,350,000.

Maybe it’s because the outgoing CEO of CVS Health, Larry Merlo, got paid $15,350,000 during the pandemic – I don’t know – but I would really like to know the decision-making and the logic of why that was allowed to happen.

COMMISSIONER LEE: Going back to your first point about the time frame of implementing Senate Bill 50, there are a lot of moving parts and this is the first in the country the way that we’re implementing.

We are moving to a single PBM
but we’re still holding the MCOs accountable. They will be paying for the administration. The State, however, sets the rate and we are using the fee-for-service formulary.

And as far as the CVS rate reduction, when we look at our system in Medicaid and we look at our encounter claims, we can tell exactly how much money was paid to the pharmacy for their dispensing fee, how much the MCOs paid and we do have that information.

It’s my understanding that the pass-thru, some pharmacies use a PSAO and that there were contracts that were on a national level rather than on a state level.

When that claim comes through, it appears that the MCOs are paying that $2 fee, but somewhere in between what the PSAO and the PBM and, then, the contract that the pharmacist has with that PSAO is where those funds are being removed. It’s not at the claim level but at least it’s within the PSAO or the PBM.

And I don’t know if I’m explaining that right and I may have to have either - I don’t know - maybe Dr. Ali, if she’s on the phone, to assist with that, but we in our system do not see
that reduction based on the $2.

MR. POOLE: Okay. So, this was not at all driven or asked for by Medicaid?

COMMISSIONER LEE: No, it was not.

MR. POOLE: This had to do between the contractual MCO and the providers themselves and the PSAO’s.

COMMISSIONER LEE: Yes, sir.

MR. POOLE: Okay. And, then, secondly, and you will think I’ve gone definitely in a different direction, but I want to put this in everybody’s mind and this is the best committee, I think, to bring it up.

I am really tired of going to funerals of individuals who have committed suicide that have had their medication changed.

I have five young people in my community over the last seven to eight years that have committee suicide, and on every single occasion when I talk to the parents, they were either waiting to be seen by the doctor again because the change in medication wasn’t working for them, or they had just been changed on a new medication.

I realize this is a very
complicated issue, but I would really like for the Medical Board or a Therapeutics Board to come up with a solution.

There needs to be a protocol set out there that when you are adjusting mental medications to help alleviate any kind of depression or any kind of mental disorder, that there needs to be something followed, whether there’s checks and balances every two to three days, whatever that protocol is.

Obviously I’m not a prescriber but I certainly have seen the results, and I in my little world in Western Kentucky have had too many deaths just due to dose changes or drug changes.

And I would really like for some of the mental health people on this call to weigh in because this isn’t just needed in Kentucky. It’s needed nationwide.

And I think those of us who know about your antidepressants or any of the wide range of medications, many times it’s a trial and error whenever a practitioner is going off of, yes, the literature that’s out there. but it’s not like we can do blood tests of norphenylephrine, serotonin or any of the brain chemicals. We can’t get levels of
them nor can we — if we did have levels of them, is there a standard that helps us point in the right direction?

So, again, I think this is a big problem and it seems to be affecting the adolescents up to the early twenty-somethings, and I just think it’s a tragedy every time. And when you’re just talking about dose changes and drug changes causing this issue, I would like for us to be able to put our minds together and do something about it. Thank you.

COMMISSIONER LEE: Thank you.

MS. EISNER: I’d like to comment on that real quickly. Part of the things, and I absolutely agree with what you’re saying, Ron.

One of the things that exacerbates this issue as well is when a patient is discharged from a hospital, they go out with a certain amount of medications that they have been put on, and the docs are reluctant to write too long of a prescription because of access to medications and potential risk and harm.

However, the problem is often exacerbated by not being able to get post-discharge patients from a behavioral health hospital or an
acute hospital with these meds into followup care in a timely way.

And the MCOs have a standard with NCQA that there’s supposed to be an ambulatory followup within seven days and within thirty, and that guideline is often met but it’s with a therapist, not a prescriber.

And, so, I’d love a deeper dive into this problem, but I think that is one thing that is additionally challenging to the physicians who prescribe in a hospital and how long they can and should prescribe after discharge.

COMMISSIONER LEE: Thank you both for those comments. And I agree, Mr. Poole, anytime we lose anybody in our society, it’s devastating on many levels, for the parents, for those of us who are supposed to be caring for these individuals.

And we’re not going to solve it today but what does our data tell us? Can we do retrospective reviews on some of these individuals? What do we need to look at to tell us what is and is not being done for our Medicaid members? What sort of reports can we look at that can point us to information and help us identify interventions we can
do now to prevent this in the future?

Again, we’re not going to solve that today but it’s something that this committee definitely needs to think about. And, again, it goes back to using our information and our data to drive policy decisions and to drive interventions.

Medicaid covers now one out of every three Kentuckians and we have a whole lot of data. We just need to be able to turn that data into information to help us move forward.

And, again, when we think about these issues, what would our data tell us? What reports do we need to look at, and, then, what interventions do we need to put in place as we move forward to ensure that we are doing the best thing that we can and making this population in Kentucky healthier and informed about decisions?

So, that’s my ask of this committee. Help us. We are here for the same reason. Medicaid - and you all have heard my philosophy, you know my standpoint - Medicaid was created for the Medicaid member. We can’t take care of our members if we don’t listen and take care of our providers.

So, help us solve this problem
by designing those reports, moving forward in a very thoughtful manner so that we can identify those interventions that we need to implement and, again, short- and long-term targets.

What can we do in the short term and what do we have to look at in the long term and what’s our baseline data? How do we measure our success going forward? If we’re not being successful, what do we have to do to go back and re-examine and re-evaluate our plan.

MR. POOLE: Commissioner Lee, I would love for us to put an ad hoc committee together on this, and I know we’re all kind of committee and meeting-out but this is – I mean, obviously, this is very important.

Hopefully I’m pronouncing your name right. Nina, I think she hits upon a really good kind of deficit problem, and I would definitely encourage you, Commissioner Lee, I know that I could help put a network of pharmacies together statewide that would help with those behavioral health discharges to where we could do a transition of care in pharmacies that we would check up on them.

I would like for us to be able to hopefully bridge that gap, that we would keep the
communication line open with the patient and the provider, the prescriber and even counselors, that we could definitely report when there’s potentially an issue or, hey, this person failed to pick up their medicine. We’ve called them. We’ve tried to deliver it. We’ve done whatever.

I think there’s gaps that we can really help fill that would make it hopefully - and the only success that we would ever be able to measure is obviously a decrease in the suicidal rate, and we would hope that over time, that would show what the progress is.

COMMISSIONER LEE: And I think that the Behavioral Health TAC would definitely be interested in this topic also. And we have access, of course, to Dr. Benzel, and we have several behavioral health experts in the Department, including Leslie Hoffmann.

So, let’s figure out what we need to do, what we need to look at and move forward with a clear plan in place.

MS. EISNER: Dr. Theriot also had a comment just now in the Chat box which I think is important to consider as the committee is put together and that is the impact on primary care.
doctors when they are not able to refer their patients to a behavioral health provider in a timely way because many of them are not comfortable initiating or managing the medications for substance use and psychiatric conditions. So, thank you.

DR. BOBROWSKI: This is Garth Bobrowski. I’ve got two questions. The first one, is Senate Bill 50, you talked about the $10 - did I write it down right - dispensing fee? So, does that mean it’s going to be increased from $2.15 to $10, or did I write it down wrong?

COMMISSIONER LEE: So, currently, the Department for Medicaid has a fee-for-service pharmacy benefit, and in fee-for-service, we do pay $10.64 for our dispensing fee.

The six MCOs, they currently have different Pharmacy Benefit Managers and I think their dispensing fee may vary some based on different variables. And, so, all MCOs, all dispensing fees for medications will be $10.64.

Now, that does include some compound pharmacy drugs. I know that some of the MCOs pay a higher dispensing fee for those compound drugs, but following the fee-for-service, it will be $10.64. So, that’s one area to try to take note of.
DR. BOBROWSKI: My second thing - this is Garth Bobrowski again - I had a question a little bit off this subject here, but I got this email yesterday and I noticed Dr. Adam Rich was on the call.

And, Commissioner Lee, I’m not trying to put anybody on the spot on this because I see this kind of as a good thing, but, then, I can see some other things going on with it.

But the email says this is from a dentist that said he has a staff member that works at Kroger part time, but they noticed United Healthcare was giving out healthy food cards which I guess was in the email was that the Medicaid recipient could use anywhere from $50 to $75 on healthy foods, not Pepsis and Cokes, and that’s the good thing. It’s healthy foods but I guess this was something new to the dental office person that sent me this email.

So, I didn’t know if anybody - and, like I said, I’m not judging. I just wanted information on that.

COMMISSIONER LEE: If you send me that email, I can get some information, but we all know about social determinants of health. An
individual’s health is not simply just giving access to care. There’s housing, transportation, food, those sorts of things to keep individuals healthy.

And that’s one thing that the Managed Care Organizations definitely bring to the table. They have more flexibility to reach out to those members and identify areas that are going to improve that individual’s health. A really good example is a voucher for healthy food.

So, again, that’s taking care of the entire member rather than just their medical needs to make sure that they can remain healthy.

DR. BOBROWSKI: And that’s good. Even the Dental TAC was kind of like, Ron, what you were just saying about trying to get different TACs together and forming some ad hoc committees of just working together on some of these issues to improve the whole health of people. So, I welcome your point on the pharmacy folks. So, thank you.

DR. HANNA: I just want to make a couple of comments since we’re on Senate Bill 50. As we’ve all heard today and going back over the past few years, we’ve had several pieces of legislation pass just with the end goal of ensuring appropriate reimbursement for pharmacies.
So, I want to say that these efforts are greatly appreciated, as are the efforts of those who are working to implement and have worked and continue to work to implement Senate Bill 50.

As Dr. Bobrowski mentioned of the dispensing fee, we truly do appreciate the $10.64 dispensing fee because it does recognize the value of what a pharmacist can bring as far as their professional services, that it’s very, very important.

But I just want to - and, Commissioner Lee, you mentioned this before - this is a very challenging thing and we’re working through it obviously, but as we implement, I’m happy to hear that we’re going to evaluate and monitor this closely to see not only how this affects Medicaid but also to ensure that pharmacies are fairly compensated to the point that they can be sustainable.

And at the end of the game, the primary goal is to make sure that our beneficiaries have access to pharmaceutical care and services. I think that’s very important.

And, so, to go forward, I’m glad to hear that you all are going to be monitoring it very closely, and I think it’s important that all
stakeholders and the Department for Medicaid Services continue to work together collaboratively and keep those open lines of communication. So, thank you for that.

DR. PARTIN: On the formulary, I have a couple of comments and also related to what Ron said.

Of course, suicide is the most horrible end point for it all but there’s other consequences when patients don’t get their medication, whether it’s medical or psychiatric.

But for the psychiatric people, as we move into this single formulary, I think ultimately it’s going to be more beneficial because we’ll have more consistency with the medications; but, in the short run, people are on medications, and with the change in the formulary, they’re being required to switch to other medications.

And I would ask that maybe there be more consideration and make it easier for providers to continue to keep patients on the medications that they’re stable on and that they’re currently taking rather than forcing them to be switched in a way because, one, it takes a while to get medications preauthorized, and, two, with the
psychiatric patients, if you can’t meet their need almost immediately, sometimes they’re lost to you totally because they just don’t have the patience and a lot of times it’s because of their illness that they can wait to have you go through the process of getting drugs preauthorized.

So, in the short term, I would ask that there be some more leniency to allow people to continue on their current medication so that they can remain stable while we’re making this change to the single formulary.

COMMISSIONER LEE: And Senior Deputy Commissioner Veronica Judy Cecil has been working very hard on this, but that’s our goal is to ensure that there’s no disruption of services for individuals and that this is actually pretty seamless for our members.

And I’m not sure, Deputy Commissioner, if you want to add anything to Dr. Partin’s comments related to grandfathering in certain medications.

MS. CECIL: Thank you. We agree with you, Dr. Partin. There will be a ninety-day grandfather period and there’s letters going out. Providers, prescribers should be getting a letter
that goes out June 1\textsuperscript{st} and we’ll post this
information as well to make sure everyone understands
about the ninety-day grandfather period. Members
will get a letter as well about it.

We will be assessing during
that ninety days looking at is there another drug
that the person could be moved to. This is about
making sure that the member has the appropriate drug
and that’s what we will use those ninety days for is
to see if does it make sense to move them to another
drug or does the member need to stay on the drug that
they’re on.

There will be a lot of review
of that during that period of time, and that’s the
reason we did the ninety days. We want to make sure
that we’re doing everything we can for continuity of
care.

DR. PARTIN: Thank you.

DR. ALI: This if Fatima. I do
want to mention that the PDL drugs that we currently
have in place, those will not change. The ninety-day
grandfathering applies to the drugs that are not on
the PDL.

So, currently, some of the MCOs
manage these drugs a little differently. So, we’re
going to follow the fee-for-service formulary with that respect.

COMMISSIONER LEE: Thank you, Dr. Ali and Deputy Commissioner.

DR. PARTIN: Okay.

Commissioner, was your report including Number 6 on the agenda, an update on Legislative Session?

COMMISSIONER LEE: Yes. Yes. I didn’t give an update of every piece of legislation but those that we’re working on, and if you want all of the legislation reviewed at the next MAC. I just gave the highlights for you.

DR. PARTIN: Okay. Thank you. I just didn’t know if we were ready to move on to the next agenda item.

So, next up we have the TAC reports, and we have a couple of other items on the agenda following the TAC reports.

So, I would like to ask the TAC members to keep your reports to the most important information that the MAC needs to know and, then, your recommendations so that we can give everybody an opportunity to speak and if there’s any questions and also to end our meeting on time.

So, first up is Therapy.

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DR. ENNIS: Good morning. This is Beth Ennis. I’m the Chair of the Therapy TAC. The TAC met on May 11th virtually. We did have a quorum and members of most, if not all, of the MCOs present.

The big items - we don’t have any specific ask. We’re working through two big issues. One is ongoing administrative burden issues that just continue to pop up and we’ve provided DMS with a list of the most frequent reoccurring issues.

We are continuing to add to that document. So, I’m going to give them an updated one soon.

The other piece is our fee schedule. When it got updated, there was about a 10% cut in already ridiculously low reimbursement rates and it was explained to us that that was due to Medicare cuts.

My understanding is that Medicare had planned 9% cuts but have decreased that to a 2% cut. So, we’ve asked them to revisit that fee schedule and hopefully correct it; if not, to provide us an explanation why it was so much deeper of a cut than what Medicare did because people are not able to keep their doors open with what is being
reimbursed. Between that and the way the MCOs are adjusting payments and removing modifiers, it’s just been a really difficult six months so far.

We don’t have an ask of the MAC at this point but appreciate the Cabinet continuing to look at these issues with us. Thank you.

DR. PARTIN: Thank you. Primary Care.

MR. CAUDILL: Good morning. This is Mike Caudill. I’m the Chairperson of the Primary Care TAC.

In our last meeting on May 6th, we talked with Ms. Cecil about the workgroup that was going on. We’ve had one meeting, and since that, a second one has been scheduled.

It was a very informative meeting. It went very well and the next meeting intends to go a little bit more further into what was raised. About nine people submitted comments, and this next meeting of the workgroup will be concentrated on the provider end which is a good thing.

The other thing we’d like to talk about is our presentation by former Justice Gene Smallwood concerning the payment methodology for
same-day Medicaid multiple visits. He had done research, had looked at twenty states including adjoining states around Kentucky; and of that, Kentucky was the only state that did not make payments for same-day multiple visits.

And fifteen of those twenty states made payments based upon three different areas, and that’s primary care, behavioral health and dental.

Based upon his study, he felt there was a strong trend going on for payment of multi-day visits and felt like that the current methodology of the state to only pay for one visit was hindering.

It was a burden upon our elderly and people on fixed incomes and trying to arrange to go to doctors, and that it was a burden upon primary care and rural health in trying to hire and to retain qualified providers on the one hand, and, on the other hand, it restricted their ability to be able to expand services to their patient population and to open new clinics which, in turn, had an adverse affect upon our patients and our Medicaid recipients.

To that end, a recommendation
was made to forward to the MAC and I’ll read that at this time. It is this committee’s recommendation to
the MAC that they request DMS to review their same-
day multiple-visit payment methodology and report
back to the MAC comparing Kentucky’s methodology of
that of surrounding and other states to determine if
Kentucky’s approach is in parity with the majority of
other states, and if not, to suggest an approach for
Kentucky to become more mainstream with the trends
across the country in reimbursement for same-day
multiple-visit payment methodology.

And, again, out of those twenty
states that were reviewed, Kentucky was the only one
that did not pay for multiple visits in some type of
an approved procedure.

And that’s my report and
recommendation, Madam Chairperson.

DR. PARTIN: Thank you, Mike.
I thought at the last meeting, the Commissioner told
us that that problem had been fixed and that patients
were able to receive or providers were able to
receive reimbursement when patients had multiple
visits on the same day. Is that not correct?

COMMISSIONER LEE: I think
that’s a different issue, Dr. Partin. What Mike is
talking about is the FQHC/RHC reimbursement methodology. When they receive a PPS rate, a prospective payment system rate, that rate is all-inclusive.

However, at the clinic, if an individual sees two different providers at two different locations, that’s a different issue.

DR. PARTIN: Okay. Thank you.

MS. HUGHES: Mike, could you send me your recommendation from the TAC, please. I haven’t received a recommendation from the Primary Care TAC. I think you just gave one.

MR. CAUDILL: I did give one. It is my understanding it was sent in. If not, then, certainly I can follow up on that.

MS. HUGHES: Okay. I may have missed it but I don’t think I’ve seen it. If you don’t mind, I would appreciate it.

MR. CAUDILL: You’re awful good, Sharley. I wouldn’t think you would miss anything.

MS. HUGHES: Oh, I do sometimes. I’m sorry.

DR. PARTIN: Thanks, Mike.

Podiatry.

DR. ROBERTS: No TAC.
DR. PARTIN: Physician Services.

DR. McINTYRE: Hi. I’m Dr. McIntyre. I’m the Vice-Chairman of the TAC and we did not meet.

DR. PARTIN: Okay. Thank you.

Pharmacy TAC.

MR. POOLE: Madam Chair, this is Ron Poole from the Pharmacy TAC. I have three motions that came out of two meetings. And even though they are short motions, I want to let the MAC know that a lot of work and research went into each one of these.

Anyway, the first one is - and what I would like, again, with Commissioner Lee’s - I appreciate her coming with a more formal I guess response to what the TACs report to the MAC, but it would be nice to get a formal response from Medicaid on these.

Recommendation of standard dispensing fee for specialty drug claims. We looked at all kinds of national data, the requirements that are put into place for specialty pharmacies to dispense but basically came up with specialty pharmacy accreditation status would not be required in defining a specialty pharmacy.
The P&T Committee needs to define specialty pharmacy drugs and apply a $73.58 dispensing fee as a standard dispensing fee for specialty pharmacy prescription drug claims.

So, that is one that we would like to be considered. And, Sharley, I will be sending you a copy of these three that I’m talking about today.

We have taken on quite a bit of topics, and respecting the need to save time, I won’t go over all the topics that were discussed, just the ones that we came up with motions on.

The next one is on the reimbursement per prescription guidelines. Basically, it’s what the dispensing fee needs to be applied to. Certain arguments would say, well, if you fill a prescription every two days for fifteen days, that’s a thirty-day supply. And if somebody is trying to get a dispensing fee on each one of those, we’re hoping that there’s going to be processes put in place to audit these people and take back those dispensing fees.

But due to the nature of the treatment of using Suboxone if the Suboxone clinics are even in regular primary care, we would request
that the minimum be placed down to seven days. So,
the official wording is: Due to cases like Suboxone
dosing and prescribing limitations of certain
prescribers, a motion to recommend single MCO pay
full dispensing fee for every claim down to a minimum
of a seven-day supply.

Now, just adding something to
that would be we realize that some methodology will
be put in place to make sure that people aren’t
taking advantage of that, and we certainly understand
that and respect that. So, that’s the second one.

And, then, the third one and
last one, I worked on this particular workgroup.
This motion: The following is a recommendation to the
Department for Medicaid Services on a compounding
reimbursement model.

I’ll just read: The situation
is Kentucky Medicaid recipients need coverage for
both non-sterile and sterile compound medicines to be
reimbursed by DMS so they can receive the best drug
therapy for their medical conditions.

I’ll just add, many times this
is at a cost savings. Part of this testimony, if
this moves along, but the background information we
put in there, the University of Kentucky Medical
Center, how much they just write off in the compounds that they make a lot of time for their pediatric patients because it’s the best therapy, even though it’s not reimbursed, and it’s the cheapest way to go for the patient.

But, anyway, the assessment is non-sterile and sterile extemporaneous compounds are necessary for optimal treatments. We need a compound reimbursement model in place where the claims processor and Medicaid are confident in paying the legitimate claims to avoid a fraud or potential for fraud.

So, goals on both sides. The goals for the providers is providing the service at the cheapest and best therapy possible, and we realize the goal of Medicaid is going to be paying legitimate claims and not allowing for fraud or potential for fraud.

So, this is actually an SBAR statement that I would like when Commissioner Lee and her staff look over it. I would really invite even Dan Yeager with Medimpact to work with us, maybe with just a workgroup, to come up with this model that would work for him and his company with the single payer model.
So, anyway, I will get all this to you, Sharley. And, Madam Chair, I yield to you and thanks for your work and thanks for Commissioner Lee to come up with a more standardized way of responding to these requests from the TACs. Thank you.

DR. PARTIN: Thank you, Ron.

Optometry.

DR. COMPTON: Madam Chair, this is Steve Compton from the Optometric TAC.

We met on May 6th. We had a quorum and I think all the MCOs and subcontractors were there.

We had various topics of discussion concerning credentialing and payment for some claims, but we’re working through them and I’m optimistic that things will keep getting better and better, and we have no recommendations at this time.

DR. PARTIN: Okay. Thank you.

Nursing Services. Intellectual and Developmental Disabilities. Do we have a report from Intellectual and Developmental Disabilities?

MS. HUGHES: They did meet but I don’t believe they have anything on here to present.

DR. PARTIN: Okay. Thanks,
Sharley. Hospital.

DR. RANALLO: This is Russ Ranallo, the Hospital TAC Chair. The Hospital TAC met on April 27th with a quorum. We don’t have any recommendations. There were several items that were gone through, just follow-ups from prior meetings, a couple for this group.

One, we talked about patient transportation. We’ve had numerous reports of hospitals all over the state with transportation issues. When a hospital is full, we need alternative levels of care and we’re having a lot of problems getting timely and secure transportation.

This is causing some patient safety issues and some constant criticisms. You have hospitals that are calling in more expensive transports like air transports in order to move their patients.

We realize the Cabinet doesn’t regulate the ambulance but we wanted to bring it to their attention because it’s an access issue for one from our viewpoint.

The Hospital Association has had a workgroup that has met and they are documenting specific issues and problems and they’re going to
attend the next TAC meeting to share some of that
information that we will send up to the MAC.

And, then, the other item was
on the agenda today, the psych hospital EMTALA
requirements but we still don’t have resolution on
that issue. I know the detailed information has been
sent numerous times. That’s going to happen again
and we’re going to follow up at our next meeting in
June.

DR. PARTIN: Thank you. Home
Health.

MS. STEWART: The Home Health
TAC did meet. We have no recommendations at this
time. Thank you.

DR. PARTIN: Thank you. Nursing
Home.

MR. MULLER: This is John Muller
from KAHCF.

The TAC did meet virtually on
May 19th. We discussed several issues affecting
nursing facility providers. The agenda included a
followup on the Association’s request for a Medicaid
rate add-on for 2021, a 2020 COVID add-on and bed
reserves, an update on inflationary adjustment to the
price and many Medicaid billing issues, and, then, a
The Department for Medicaid gave an update on a State Plan Amendment that has been filed regarding the nursing facility provider request for the rate add-on and CMS just yesterday approved that. So, the Association and DMS are working on implementing the 2021 COVID add-on.

Also, several billing issues were raised and discussed including during the pandemic, the inability to change patient liability and also Medicaid eligibility for State Guardian residents. That has been an ongoing challenge.

So, the Association is going to share documentation on how surrounding states process the guardianship for Medicaid eligibility and will report back at the next TAC.

And, then, lastly, the TAC members requested the Department for Medicaid consider rebasing the nursing facility price, make the necessary changes to the Medicaid price-based regulation in order to re-base the price for January 1st, 2022 and going forward.

We’re asking for this regulation change because the price component was last set in 2008 using 2007 data. So, that’s really
incongruent with attracting and retaining the staff
we need to operate by using wage data from fourteen
years ago.

So, the Association will ask
for the Department’s decision to change the
regulation at the next TAC meeting which will be held
June 30th. That’s all we have to report. Thank you
very much.

DR. PARTIN: Okay. Thank you.

Dental TAC.

DR. BOBROWSKI: Yes. This is
Dr. Garth Bobrowski and I’ll be shorter.

The Dental TAC met on May 14th.
We did have a quorum. Just a little background. The
dental access to care is continuing to decline. One
factor is that many of the procedures are being
reimbursed at below cost, especially for adults.
There’s a separate fee schedule for adults than there
is for children.

The TAC had recommended a fee
increase from the State on some procedural codes but
recent correspondence has denied this request.

So, the motion from the Dental
TAC is that the Dental TAC recommends the MAC start
discussions on additional funding for Medicaid that
may include a soda tax to be used to help fund oral health and other health initiatives and those funds are to be used exclusively for Medicaid.

This has been done in other states and municipalities. I believe Philadelphia was one of the last ones to get this passed, but some states are funding most of their Medicaid Program through this means.

And I hate taxes worse than anything, but in dentistry, the soft drinks and sugary drinks are just killing our smiles in this state.

We had a good lengthy meeting with our TAC. We went over a lot of other items but this was the emotion that we came up with, and I will respectfully submit this and thank you very much.

DR. GUPTA: Dr. Bobrowski, this is Dr. Gupta, if I may make a comment, Dr. Partin.

The soda tax that you bring up is something that I’ve actually been working on or trying to work on for a couple of years, and my brother actually submitted a proposal to the KMA a few years ago about that. It was turned down.

But you are absolutely right. I have done a lot of research on this and there are
several states in the country who support their entire or a lot of the Medicaid budget through a soda tax and there’s different ways to do it. It does not necessarily have to be a tax on the actual consumer. It could be on the company.

There’s a lot of different ways to approach it but that gets to the root of the problem. Either Medicaid gets the funding or the consumers choose not to purchase it and, then, in itself reduces their health risks. So, I totally support that.

DR. BOBROWSKI: I had a lady, a patient just last week that she’s drinking twenty-four soft drinks a day and I won’t go any further but I appreciate your support.

DR. GUPTA: It gets to the root of so many problems—diabetes. If we could prevent these things from happening in the first place, then, our cost to all of us significantly drops.

DR. PARTIN: Dr. Bobrowski, I also think that that’s an excellent idea and I know that not only for dental but, as it was just pointed out, that it’s also a problem for I think everybody’s health in so many ways.

In order to do something like
that, the professional organizations would probably have to get together to have a bill sponsored in order to increase that funding for Medicaid.

So, perhaps that’s something, if the Dental TAC or one of the other groups wants to reach out to the professional organizations, I’ll be glad to reach out to the Kentucky Association of Nurse Practitioners and Nurse Midwives on that, and that is something that we could all work together on to promote in the next Legislative Session or beyond.

DR. ROBERTS: Please include the KPMA. I’m on the KPMA Board. So, I would certainly be happy in bringing it to their attention as being a co-sponsor for this.

DR. GUPTA: That’s something that each of our TACs could work on because what we did just as the KMA, it was just one group, and it was turned down; but I think that if it came from, as you mentioned, several different medical groups, it would be so much more effective in legislation.

DR. PARTIN: Absolutely.

DR. GUPTA: So, how would we go about doing that, something like that?

DR. PARTIN: I think we need to talk to our professional organizations. I’m sorry.
Go ahead, Garth.

DR. BOBROWSKI: You’re exactly right, Dr. Partin. This is something that even the Kentucky Dental Association can initiate and we’ve actually got some MCO support for this.

But like you just said, if we’ve got other TACs, other state organizations that will co-sponsor and sign on with the sponsor of a bill and, then, it takes a grassroots effort of working with each of our lobbyists or working with our legislators throughout the summer, fall because once January hits, the legislators are swamped, don’t have much time.

It’s going to take some time to work on it and there’s a lot of data that the American Dental Association has already gathered on this situation.

So, it is kind of one of those things that the more sponsors or co-sponsors that you get and work the legislators because the soft drink industry is also, they’re a bigwig in all this, and if we could work with Behavioral Health and other groups, Children’s Health and start making an initiative that, man, this much soft drink and sugar, it’s just not healthy, like you said, diabetes,
obesity, teeth, face, whatever, but I think it’s
going to be a cooperative effort to get results.

DR. PARTIN: Okay. Thank you.
I think we can talk about that outside of the MAC
meeting more.

Next up, Consumer Rights and
Client Needs.

MS. BEAUREGARD: Good morning.
Emily Beauregard. I’m the Chair of the Consumer TAC
and we had a meeting on April 20th. We met virtually
with a quorum present. We had no recommendations to
put forward and we discussed a number of issues that
are in the report that I sent to you, Dr. Partin,
just really yesterday. So, hopefully, everyone has a
copy of that to review.

In the interest of time, I just
want to highlight one of the issues that we
discussed. This is something that we have raised at
MAC meetings for probably the past two years now
which is the Public Charge Rule.

This Public Charge Rule, there
were restrictions put in place in 2019 under then
President Trump, and these restrictions had a
chilling effect on Medicaid enrollment with
immigrants regardless of their immigration status
being afraid to enroll in Medicaid even if they or a family member was eligible.

And, so, the good news to report is that after going through a couple of years with these restrictions, the Biden Administration has reversed course and those restrictions are no longer in place.

So, we have gone back to the prior guidance which was set in 1999, and what this effectively means is that people that apply for Medicaid, KCHIP, SNAP benefits, if they are eligible for those benefits, it won’t have an effect on their ability to at some point get U.S. residency.

So, that’s good news, but I think it’s important to note that this chilling effect continues. We need to make sure that people are educated about the change and that people trust that they can enroll in benefits without it having a negative impact on their ability to gain residency or citizenship status in the future.

And, so, it’s work that we all need to be doing, and we appreciate that the Cabinet, that DMS has been working with us to update the memo on the Public Charge Rule and get information out to workers and to beneficiaries.
So, that’s all I’ll share for today. Thank you.

DR. PARTIN: Thanks a lot.

Children’s Health.

MS. KALRA: Hi. This is Mahak Kalra, Chair of the Children’s Health TAC. Unfortunately, we did not have a quorum but we did meet. So, I don’t have any recommendations for today.

DR. PARTIN: Thank you.

Behavioral Health.

DR. SCHUSTER: Good afternoon. Sheila Schuster, Chair of the Behavioral Health TAC. We met via Zoom on May 11th. We had all six of our TAC members there, as well as representatives from Medicaid and from the Department for Behavioral Health, and all six of the MCOs were represented as well as a number of members of our behavioral health community.

Good news and we thank Commissioner Lee. We’re still continuing to work on targeted case management. I’ve talked to you all about the importance of this.

It is still not being prior-authorized which is great, and Commissioner Lee has
put us in touch with her data specialists and we are
doing a very targeted data pull on adults with severe
mental illness to look at the impacts of targeted
case management.

So, we’re very excited about
this and I thank Commissioner Lee. We thank you for
your leadership and using data to influence policy.

You mentioned the single
formulary. We continue to hear problems with
particularly our child psychiatrists being able to
get necessary medications for kids, with all of the
changes.

People are being changed from
their medications; and as has been discussed earlier,
this has sometimes some catastrophic effects on
people.

I do appreciate Dr. Ali being
so prompt in responding to a question we had about
the upcoming changes around the non-PDL drugs and we
will be circulating that information. Veronica Cecil
also has been very helpful.

We continue to struggle with
dual eligibles. I think I brought this up last time
and Medicaid staff has gotten some examples from us.
These are people that have Medicaid and Medicare both
or have Medicaid and private insurance and we continue to have problems with reimbursement.

We’re anxious for the SUD waiver for incarcerated persons to be able to get the services starting in the jail or prison and we hope that CMS will be responding soon.

We thank you for the responses to the brain injury waiver recommendations.

We have no recommendations at this time, but I would like to respond, and I certainly appreciate, Ron, your bringing up the issue of suicides and medication.

And you all who have been on the MAC have heard me probably talk about this twenty times over the past six or seven or eight years, but if our people particularly with severe psychiatric disorders have a glitch and don’t get their medications, terrible things happen.

We see that often people end up not coming back to get it after the glitch is supposedly resolved. We see people ending up in jail because their behavior is problematic for society. We see people ending up being re-hospitalized. We see people in homelessness, and, yes, we do see people with successful suicides.
So, certainly, the Behavioral Health TAC would like to work with the Pharmacy TAC. I think, Nina, your forum for your hospitals that are doing psychiatric disorders, we need to put our heads together, and I do think that we have significant problems still with medications.

I think what’s happening – and we should have some of our psychiatrists and psychiatric nurse practitioners in this workgroup – is I think they will tell you that they are so overworked because there are so few of them that when there are multiple prior authorization requirements, they simply change their prescribing behaviors and they give into that kind of pressure because they simply cannot take the time to submit and submit and submit.

And the other problem is that we’re still waiting for days sometimes for those PA’s to be approved and that gap is something that we really cannot tolerate.

So, I really welcome the opportunity to work with you all on this and I will be in touch with you. Thank you very much.

DR. PARTIN: Thank you, Sheila.

I had just a couple of things to add related to some
of the things that we’ve talked about with the TAC.

And Sheila just mentioned it

but I would also like to have, if any group is
formed, psychiatric nurse practitioners included in
that because they are practicing a lot in our rural
areas and providing psychiatric care and I think that
perspective is important.

And, then, the other thing is,

Commissioner, I had a question. I’m wondering if you
know or have any idea - you probably don’t know
because nobody knows - but if you have any idea when
the emergency orders are going to end?

COMMISSIONER LEE: Not at this
time. I don’t know at this point.

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

COMMISSIONER LEE: We don’t know
at this point.

DR. PARTIN: Okay. That’s what
everybody says. Thank you.

Moving on to New Business, the
first item is Judge Phillip Shepherd of the Franklin
Circuit Court ruled in late April that the bidding
process, which was the second one, for awarding the
MCO contracts was flawed and must be rebid.
What are the immediate and long-term effects of the Judge’s ruling that the MCO contracts must be rebid, and how does DMS plan to proceed?

COMMISSIONER LEE: Currently, the Judge’s Order is not final. So, we are waiting on the Order to become final and what additional information may be included.

DR. PARTIN: So, the next meeting or do you think you will know something before then?

COMMISSIONER LEE: We may know something by the next meeting. I think there may be a hearing on June 3rd. So, we will know more information after that hearing.

DR. PARTIN: Okay. So, I’ll put that on the agenda for the next time.

And, then, the other item, I’ve had several requests from people who are able to attend the MAC meetings, if the recording of the meeting could be put on the website so that they can know what was discussed at the meeting.

COMMISSIONER LEE: We do post the minutes after they are approved, but we’ll look into the recordings and see if they can be posted.
DR. PARTIN: If they could be posted, our minutes are basically not minutes in the traditional sense. It’s basically a transcription of everything that was said.

So, our approval of that is based on the recording, not on somebody’s interpretation of what minutes usually are is an interpretation or a summary of what was said.

So, if the recording could be posted shortly after the meeting, that would give people who were interested in what was going on an idea of what happened at the meeting and just hear everything that was said just as everybody was at the meeting hears.

COMMISSIONER LEE: We’ll look into that and see what all is involved.

DR. PARTIN: Okay. Thank you.

And, then, last which I didn’t report but the Commissioner reported it for me was that I was invited – and I put invited in quotation marks there – to present a report to the Medicaid Oversight and Advisory Committee last week, and I just basically gave the committee a summary of everything that we discussed in 2020 and so far in 2021.

So, basically, I looked at our
minutes and I reported what we had discussed.

Does anybody have anything else
that they would like to bring up?

Well, we did really well today.
It’s two minutes after. So, if there’s no other
business, would somebody like to make a motion to
adjourn?

MS. EISNER: So moved.

DR. BOBROWSKI: Second.

DR. PARTIN: Any discussion?

All in favor say aye. Opposed? So moved. Thank
you, everybody. Look forward to seeing you in a
couple of months.

MEETING ADJOURNED