CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

November 19, 2020
10:00 A.M.
(All Participants Appeared via Zoom or Telephonically)

SPECIAL-CALLED MEETING

APPEARANCES

Elizabeth Partin
CHAIR

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

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

AGENDA

1. Call to order 4

2. Roll Call 4

3. Approval of minutes September 2020 4

4. Old Business
   A. Problems related to MCOs not requiring participants to see the assigned provider and inappropriate assignments. Add Certified Professional Midwives (CPMs) to the regulations as Medicaid providers whose services are reimbursable .... 4 - 7

   B. 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 3 days for providers to sign Medicaid participant's chart.. The current regulation requires charts to be signed on the day services are provided. Three (3) days would be in line with other regulations and more realistic in busy clinic settings .... 7 - 8

   C. How will open enrollment work with 2 new MCOs in January? .... 9 - 10

   D. The Consumer Rights and Client Needs TAC made a recommendation that Emergency Time-Limited Medicaid be expanded to include outpatient services, when necessary, and provide public education to Kentuckians on how to initiate an application.

   DMS Responded - The Department recognizes the vulnerability of this population and strives to provide needed services as requested. To further address the need, DMS will review other state Medicaid programs to determine if CMS has approved policies related to emergency Medicaid beyond the scope outlined in Kentucky's regulation. In addition, we will develop more comprehensive documents related to eligibility and the application process that can be used to inform both providers and applicants of the emergency Medicaid processes. Has DMS begun a review of other state programs? If so, what was

AGENDA
(Continued)

the outcome? .... 10 - 11

E. What state plan amendments (SPAs) is DMS planning to submit to CMS to incorporate some of the changes made during the Emergency Order to make them permanent?
1. Suggestions from MAC members .... 11 - 23

5. Updates from Commissioner Lee .... 23 - 31

6. Reports and Recommendations from TACs
* Therapy Services .... 32 - 33
* Primary Care .... 33 - 39
* Podiatric Care ....(No report)
* Physician Services ....(No report)
* Pharmacy .... 39 - 46
* Optometric Care .... 47 - 48
* Nursing Services ....(No report)
* Intellectual and Developmental Disabilities ....(No report)
* Hospital Care ....(No report)
* Home Health Care ....(No report)
* Nursing Home Care .... 48 - 52
* Dental 53
* Consumer Rights and Client Needs .....(No report)
* Children's Health ....(No report)
* Behavioral Health .... 54 - 59

7. MCO Reports - Passport Health Plan by Molina .... 60 - 86

8. MAC election of officers .... 86 - 87

9. 2021 Meeting Dates .... 87 - 88

10. Adjourn 88

1 DR. PARTIN: We will call the
2 meeting to order; and first up on the agenda is roll
3 call.
4 (ROLL CALL)
5 MS. ALDRIDGE: Dr. Partin,
6 that's the end of roll call. I'll turn it back to
7 you.
8 DR. PARTIN: Do we have a
9 quorum?
10 MS. ALDRIDGE: Yes, we do.
11 DR. PARTIN: Thank you. So,
12 first up on the business is approval of minutes.
13 Would somebody make a motion, please?
14 MS. ALDRIDGE: Teresa will make
15 a motion to approve the minutes.
16 MS. EISNER: I'll second that
17 motion.
18 DR. PARTIN: Any discussion?
19 All in favor, say aye. Any opposed? So moved. The
20 minutes are approved.
21 Now we will move into Old
22 Business, and, actually letter A under Old Business
23 has combined two items. The first item is problems
24 related to MCOs not requiring participants to see the
25 assigned provider and inappropriate assignments being

1 made.

2 At our last meeting, this was
3 brought up and I did mention that this has been an
4 ongoing problem for years actually. And, so, it's
5 back on the agenda to see if anything was done about
6 it or any solutions sought with the MCOs.

7 COMMISSIONER LEE: Hey, Dr.
8 Partin, this is Lisa Lee with Medicaid. I completely
9 understand the concern here but I believe this is
10 something that is out of the Department's hands. We
11 really can't force participants to see any particular
12 provider.

13 So, I think for this, my
14 recommendation would be for the providers who are
15 experiencing this issue to work directly with the MCO
16 to solve it; and maybe in the past, you maybe haven't
17 been working with the correct individual at the MCO.
18 So, I'll make sure that we can get to you the correct
19 contact of each MCO to help resolve these issues
20 going forward.

21 DR. PARTIN: Okay. All right.
22 Thank you.

23 And, then, the next item is to
24 add Certified Professional Midwives to the
25 regulations as Medicaid providers whose services are

1 reimbursable.

2 COMMISSIONER LEE: I understand

3 the request. We are still in the midst of a pandemic

4 and continually making modifications to our system

5 and policies in order to accommodate emergency

6 situations. And, right now, while all this is on our

7 radar, it is not a priority at this time.

8 DR. PARTIN: Do you have any

9 idea when the Department may look at this?

10 COMMISSIONER LEE: Not at this

11 time. We do have it on a list with low priority. As

12 soon as we start moving through our priority list and

13 getting the high ticket items taken care of, then, we

14 can address this.

15 DR. PARTIN: Okay. What would

16 you suggest that the CPMs do because they're

17 delivering babies but obviously they can't get paid

18 for doing it? So, should they reach out to the

19 Department as a group or how do you think that we

20 should proceed with that?

21 COMMISSIONER LEE: They can

22 definitely reach out to the Department as a group

23 and we'll entertain any conversations with them; but

24 right now, adding that provider type isn't, again, on

25 our priority.

1 DR. PARTIN: Okay. Should I
2 keep this on the agenda until we can find a solution?
3 COMMISSIONER LEE: Yes, you can
4 continue to keep it on the agenda.
5 DR. PARTIN: Okay. Hopefully,
6 in the next two or three months, things will calm
7 down, hopefully.
8 Next under Old Business is to
9 request amendment to the Rural Health Clinic
10 regulation 907 KAR 1:082, Section 9 to extend the
11 time to three days for providers to sign Medicaid
12 participant's charts.
13 Currently, it says they have to
14 be signed on the day service is provided. And,
15 realistically, I can tell you that's not happening
16 and it's almost impossible for it to happen in most
17 cases for all charts to be signed on the day of
18 service.
19 So, I think that it's something
20 that is important because providers don't want to be
21 in noncompliance with the regulation, but, then,
22 again, the practical aspect of it is that in clinical
23 practice, it's not possible to always be in
24 compliance.
25 COMMISSIONER LEE: We understand

1 the request. We know that during COVID especially,
2 there could be some extenuating circumstances, but,
3 again, this is something that we have on our list but
4 it hasn't risen to the magnitude of a high priority
5 at this time but, again, something that can stay on
6 the agenda.
7 And I think that nationally,
8 there's a 72-hour rule to sign charts.
9 DR. PARTIN: Correct. So,
10 that's why, on this new regulation, when it said on
11 day of service, it was kind of a surprise. Can we
12 have some kind of assurance from the Department that
13 providers aren't going to be penalized?
14 COMMISSIONER LEE: Definitely
15 during COVID, we'll keep that in mind. And since the
16 national rule is 72 hours, I would think that that
17 72-hour rule would override the one day that's in our
18 regulation.
19 DR. PARTIN: Okay. I'll just
20 keep that on the agenda as a reminder.
21 COMMISSIONER LEE: Okay. Thank
22 you.
23 DR. PARTIN: And I'm sorry,
24 Commissioner, but it's almost like Old Business is
25 almost part of your report and I apologize for that

1 but it kind of falls that way.
2 COMMISSIONER LEE: That's okay.
3 DR. PARTIN: The next one is how
4 will open enrollment work with the two new MCOs in
5 January.
6 COMMISSIONER LEE: We are
7 currently in open enrollment. It ends December 15th.
8 Individuals who wish to change their MCO have a
9 selection of six MCOs currently. And if they choose
10 not to select a new MCO, they will stay with the
11 current MCO to which they are assigned.
12 DR. PARTIN: Okay. So, it's
13 pretty straightforward, then, for the participants.
14 COMMISSIONER LEE: Yes. They
15 have received their information and, again, open
16 enrollment currently ends December 15th.
17 DR. PARTIN: Has the Department
18 received many questions from participants about
19 enrollment?
20 COMMISSIONER LEE: Not that I am
21 aware. It hasn't risen up to my level if we've been
22 having a lot of questions. I think the materials
23 that we sent out were pretty self-explanatory and
24 easy to follow. We have issued some FAQs and they
25 did receive their information. We have additional

1 information on our website. So, I think that it's
2 going pretty smoothly thus far. I haven't heard any
3 major issues or concerns.
4 DR. PARTIN: Okay. And at my
5 level, I haven't either.
6 COMMISSIONER LEE: That's good
7 to hear.
8 DR. PARTIN: So, next, the
9 Consumer Rights and Client Needs TAC made a
10 recommendation that Emergency Time-Limited Medicaid
11 be expanded to include outpatient services, when
12 necessary, and provide public education to
13 Kentuckians on how to initiate an application.
14 And, then, DMS responded that
15 the Department recognizes the vulnerability to this
16 population and strives to provide needed services as
17 requested. To further address the need, DMS will
18 review other state Medicaid Programs to determine if
19 CMS has approved policies related to emergency
20 Medicaid beyond the scope outlined in Kentucky's
21 regulation.
22 In addition, we will develop
23 more comprehensive documents related to eligibility
24 and the application process that can be used to
25 inform both providers and applicants of the

1 emergency Medicaid processes.
2 So, the question is has DMS
3 begun to review of other state programs? If so, what
4 is the outcome?
5 COMMISSIONER LEE: And I have to
6 say I don't think that we have begun an in-depth
7 review of this at this time. So, as soon as we get
8 that done.
9 I think the priority will
10 definitely be to develop some informational purposes
11 to put on our website to keep individuals informed of
12 the application process. And as soon as we get that
13 done, we will let the MAC know, but that is something
14 that we do need to do but have not yet undertaken the
15 task.
16 DR. PARTIN: Okay. So, when we
17 come to the TAC reports, I'll ask the Consumer Rights
18 and Client Needs TAC if they're happy with that
19 response.
20 And next, State Plan Amendments
21 or SPAs that DMS is planning to submit to CMS to
22 incorporate some of the changes made during the
23 Emergency Order to make them permanent.
24 At the last meeting, we talked
25 about suggestions coming from MAC members. And, so,

1 I have a few suggestions and, then, I would like to
2 go through with the MAC members if you all have any
3 suggestions for the Commissioner.
4 So, I'll start. What I would
5 like to ask is that RHCs continue to be able to
6 provide telehealth services because that was part of
7 an emergency order to allow the RHCs to remotely
8 provide care, allow telephone visits with
9 reimbursement and allow telehealth on platforms such
10 as Facetime or Facebook Messenger.
11 And these last two are related
12 specifically in my case because I'm in a rural area.
13 People have difficulty with Internet access. And,
14 so, sometimes the only way that I've been able to
15 communicate with them is by telephone.
16 Many of my elderly patients
17 don't have Smartphones. They'll have a flip phone or
18 they'll just have a land line. And, so, the only way
19 to communicate with them is by telephone visits.
20 And, then, because of the lack
21 of Internet service and because of the - I don't mean
22 this in a demeaning way - but people are not
23 necessarily sophisticated as far as the technology
24 and using some of the more advanced platforms. And
25 in my practice, we have found it easier to use

1 Facebook Messenger or Facetime because that's what
2 people use and they understand how to use that
3 technology and they're perfectly happy using that
4 with messaging us and doing their visits on Facebook
5 Messenger or Facetime.
6 And, so, I would ask that those
7 platforms be allowed or other platforms that hadn't
8 been around in the past. Anybody else want to speak
9 up?
10 DR. HANNA: I guess I can go
11 next. Commissioner Lee, during the pandemic,
12 pharmacists have been given the authority to order
13 and administer vaccines for ACP and the COVID vaccine
14 down to the age of three.
15 I would recommend just to
16 continue that, try to get the age down to three so
17 that we can order and administer vaccines to get
18 those vaccine numbers up and also to be reimbursed
19 for them.
20 And a question that I did have
21 was can you tell me if we will be able to bill for
22 fee-for-service for COVID vaccines going forward? We
23 know that that's coming quick and pharmacists don't
24 have the ability to bill for those services at this
25 time.

1 COMMISSIONER LEE: I believe
2 that there is an initiative underway that will allow
3 that. And I'm not sure if Dr. Jessin Joseph is on
4 the line. I see that he is and I'm not sure if he
5 can speak more to that right now.
6 Dr. Joseph, is there any
7 information you can give us on that initiative
8 underway for pharmacies to bill for a vaccine?
9 DR. JOSEPH: This is Jessin
10 Joseph. We are looking at how to operate like this
11 from the pharmacy benefit. To the extent that we'd
12 like to ensure that we're following with the Board,
13 the Board requirements as well as the emergency
14 regulations, I think we're just walking through kind
15 of what was put out by the Board yesterday or two
16 days ago - I'm sorry - and how to operationalize all
17 of that.
18 So, we are still meeting on
19 this but there is more to come.
20 DR. HANNA: I definitely want to
21 stress because it is a major issue. I think I did
22 talk to Jessin about this previously.
23 Just to shine light on it, I
24 had a practitioner call and he is servicing a home of
25 brain injury patients which all fall under the fee-

1 for-service and they didn't want to have to take them
2 out to a practitioner at this time during the
3 pandemic but there was no other way. So, there are
4 holes that we need to - you know, if pharmacists can
5 provide those services because they are going to
6 people's homes and working with them.
7 Additionally, with the COVID
8 pandemic, we've been able to order and administer
9 COVID testing. I would like to see some type of way
10 to be able to continue those type of services and
11 have a process for billing for services, testing
12 services which are under our current scope of
13 practice.
14 DR. PARTIN: Cathy, I have one
15 comment on that and that is I applaud the pharmacists
16 for doing this and stepping up, and I think it's a
17 needed service. In my rural community, the
18 pharmacies help to provide vaccines.
19 The only thing that I would ask
20 in any regulation moving forward is that the primary
21 care providers be advised when the pharmacists
22 administer the tests or provide the vaccines because
23 right now what happens is that sometimes we're
24 informed and sometimes we're not. And it makes it
25 difficult for us to provide care to the patients with

1 the continuity of care when we don't know that they
2 received these vaccines.
3 So, that's the only thing that
4 I would ask going forward. I think it's a great
5 idea, but just that we need to include in the
6 regulation that the PCPs be informed.
7 DR. HANNA: And I would agree
8 with that. And just to inform you, for children, any
9 time right now under our current regulations, if
10 you're vaccinating a child under the age of nine
11 outside of our protocol or actually any child being
12 vaccinated, there is a requirement for the
13 practitioner to be notified if they have a
14 practitioner or a pediatrician. So, that is a
15 requirement.
16 DR. PARTIN: Okay, and that's
17 not happening, I can tell you. Okay. Anybody else?
18 MS. STEWART: Dr. Partin, this
19 is Susan Stewart. The Home Health Association would
20 like to continue to recommend that telehealth
21 services remain after the pandemic and allowing non-
22 physician practitioners to sign orders.
23 DR. PARTIN: Thank you. Now,
24 that was made permanent at the federal level, and I
25 believe the Commissioner has said that DMS plans to

1 change regulations to make that permanent. And I
2 think there's legislation planned for the 2021
3 Session to fix some of the other spots to make that
4 permanent in the state as well.
5 MS. STEWART: We know. We just
6 wanted it on the record.
7 DR. PARTIN: Thank you. Anybody
8 else?
9 MS. ROARK: Yes. This is Peggy
10 Roark. I have a question for Medicaid recipients to
11 Commissioner Lee. I have been going to doctors'
12 appointments and I know I read the email that all
13 MCOs have different incentives or different programs
14 that recipients can take advantage of.
15 I was wondering how that would
16 be to share like in a doctor's office when you have
17 people that maybe cannot comprehend, read and they
18 could look at all the MCOs to choose from to see
19 which plan would be good for them. Is that against
20 rules or regulations or policies?
21 COMMISSIONER LEE: Peggy, I
22 don't think I could hear everything, but I think you
23 were talking about the different incentives that the
24 MCOs have and how individuals can be made aware of
25 that.

1 We do have a document. It's
2 called a side-by-side and it lists all of the
3 different incentive programs that they offer. So,
4 that's definitely on our website and anybody can
5 access that. Is that what you're asking or did I
6 miss the question?
7 MS. ROARK: Yes, but what about
8 when people don't have access to Internet and we have
9 elderly folks or we have people that really don't
10 understand that?
11 COMMISSIONER LEE: Are you
12 asking if we can share that with the providers'
13 offices?
14 MS. ROARK: Yes, yes. That way
15 everybody could be, like, for example, I went to the
16 doctor and they didn't know and I told them I was
17 getting a checkup and my - I'm not going to say -
18 they provide an incentive gift card, but, regardless,
19 I was going anyways, but I noticed that they have
20 different plans that would probably benefit people in
21 different ways.
22 COMMISSIONER LEE: So, the
23 question is can we make providers aware of the
24 incentives?
25 MS. ROARK: Yes. When they get

1 a patient, they get a patient and they don't
2 understand, they can have that chart to show them and
3 they can look and choose which one they want or
4 understand how it works.
5 COMMISSIONER LEE: Sure.
6 MS. ROARK: I talk to a lot of
7 people on my Facebook as networking and a lot of
8 people are not aware of any of these incentives
9 that's offered.
10 COMMISSIONER LEE: Okay. That's
11 public knowledge and it's posted on our website and
12 we'll make sure that we get information out there so
13 that providers are also aware of these incentives.
14 And that way, individuals can have that and know
15 exactly which incentives each MCO offers.
16 MS. HUGHES: Commissioner, I did
17 send that out to all the MAC and TAC members and the
18 request that they send it to their associations and
19 asked that it be shared also because we were late
20 getting all the information out, but I don't know
21 that the KMA or what other associations may have sent
22 that out.
23 COMMISSIONER LEE: Okay. Thank
24 you, Sharley. We'll make sure that it is widely
25 distributed.

1 DR. BOBROWSKI: This is Dr.
2 Bobrowski. We have shared it with the Dental
3 Association. That information has gone out to every
4 member of the Executive Board for sharing. So, we
5 have shared it out.
6 DR. PARTIN: And the Kentucky
7 Association of Nurse Practitioners and Nurse Midwives
8 also shared all that information and distributed it
9 to all of its members.
10 MS. EISNER: The Kentucky
11 Hospital Association has also distributed it.
12 And as an example to the
13 question that's on the table, at our hospital here,
14 we have copied it and laminated it and put it in all
15 of the Assessment Department offices and rooms where
16 patients come.
17 And that side-by-side has been
18 very informative and we really appreciate that very
19 simple document that shows the differences and the
20 variability of the MCOs.
21 So, I think it is fairly well-
22 distributed in hospitals and much appreciated as
23 well.
24 DR. GUPTA: This is Dr. Gupta
25 with KMA. I'm not sure if we have but I will look

1 into that.

2 DR. PARTIN: Anybody else have

3 any suggestions for Plan Amendments to CMS?

4 DR. GUPTA: Dr. Partin, this is

5 Dr. Gupta again. I just wanted to completely agree

6 with your suggestion about keeping telehealth the way

7 it is, especially allowing all the current platforms

8 that are currently available. That is so helpful for

9 our patients with their health care. So, I just

10 wanted to stress that I agree with you completely on

11 that.

12 DR. PARTIN: Thank you.

13 MR. MULLER: John Muller from

14 the Kentucky Association of Health Care Facilities.

15 We agree. In the nursing facilities, the ability to

16 do telehealth visits and, then, also telehealth

17 treatments where therapists are providing treatments,

18 nurse practitioners to give assessments to

19 physicians, it's very useful. So, we would like to

20 be able to continue that as well.

21 DR. PARTIN: Anybody else?

22 Thank you, everybody. And, Commissioner, if you

23 would let us know at the next meeting about what the

24 State plans to submit or if you know now, you could

25 tell us.

1 COMMISSIONER LEE: We definitely
2 are looking at the telehealth. We see that it has
3 been in many cases a lifesaver for our patients.
4 It's also helped providers deliver services in an
5 alternative format.
6 Telehealth was in place prior
7 to the pandemic. I think the pandemic just was the
8 driver of increasing the use of telehealth. So, it's
9 definitely something that we are looking at. We
10 definitely want to keep those flexibilities, as many
11 as we can, in place.
12 We will have to work with the
13 federal government regarding the platforms to make
14 sure that we are compliant with all of the
15 regulations governing telehealth at the federal
16 level.
17 And I think that it goes hand-
18 in-hand with its technology with our Kentucy Health
19 Information Exchange. The previous conversation
20 related to children when they're getting their
21 vaccinations, for example, if they do receive a
22 vaccination at a pharmacy, how does their provider
23 know that they have that vaccination, and I think
24 that the broader use of our Health Information
25 Exchange will help close a lot of those gaps.

1 So, I'm not sure how many of
2 the providers on the MAC utilize a KHIE platform, but
3 it could be something I think that, if it's not
4 widespread right now and not widely used, that we
5 could at our next MAC meeting have someone from our
6 Office of Health Data and Analytics develop a
7 presentation and maybe present on the benefits of
8 KHIE to this Council.
9 DR. PARTIN: Okay. That would
10 be a good idea. And maybe at the next meeting, you
11 can update us on what plan has been submitted to CMS.
12 COMMISSIONER LEE: And our
13 Office of Health Data and Analytics is also taking
14 the lead on some telehealth initiatives. So, I think
15 that together, we should be able to talk about both
16 telehealth and KHIE at the next meeting.
17 DR. PARTIN: Okay. So, if we
18 don't have anything else on those suggestions, then,
19 we're going to move into the updates from the
20 Commissioner.
21 COMMISSIONER LEE: Thank you for
22 those recommendations. We have been hearing for
23 quite some time that the flexibilities offered
24 through telehealth are very valuable, particularly
25 during this pandemic. It's also assisted with

1 reducing the number of no-show visits. So, it's
2 definitely something that we want to continue to
3 explore, and thank you all for your recommendations
4 and your input on that topic.
5 Currently, we have 1.6 million
6 individuals enrolled in the Medicaid Program. So,
7 it's going to be very important that we reach them
8 and make sure that we're driving positive policy
9 change to impact their health.
10 So, again, we've already talked
11 about open enrollment currently going on. It ends
12 December 15th.
13 Later today, I will be
14 participating in the Health and Welfare meeting
15 specifically as it relates to our copay regulation.
16 The copay regulation was deferred at the last Health
17 and Welfare meeting. There was some confusion or
18 some questions regarding the fiscal impact of that.
19 Of course, it is the
20 Department's position that copayments can definitely
21 be a barrier to care and they also impact the
22 provider. If the provider cannot collect that
23 copayment from the member, the copayment is still
24 deducted from the reimbursement amount.
25 So, it's our view that

1 copayments can be a barrier. So, our proposal, since
2 we do have a statute that we have to comply with, our
3 amended regulation lists three copayments of $1 each,
4 a $1 copayment for non-emergency use at the ER, a $1
5 copayment for non-emergency use of an ambulance, and
6 $1 for pharmacy.
7 So, we're hoping that that
8 regulation is met favorably today. We are prepared
9 to talk about and defend it at Health and Welfare.
10 So, we may have more information on that at the next
11 MAC meeting.
12 Yesterday, we spoke with our
13 MCO representatives regarding the surge in COVID and
14 the impact it's having on our hospitals and on our
15 providers. We have requested that all prior
16 authorizations be waived at this time with the
17 exception of elective surgeries.
18 We are gathering more
19 information and we'll have something definitive to
20 send out to the provider communities either by
21 close of business today or no later than in the
22 morning.
23 Again, I think the increase in
24 COVID, we know that it is having an impact on our
25 providers. We did want to make sure that we have

1 capacity not only to treat COVID but other conditions
2 that come up.
3 Also, we are developing an 1115
4 waiver for substance use disorder treatment for
5 incarcerated individuals. I think that we've talked
6 about that at previous meetings. We have closed the
7 public comment period on that. We are getting ready
8 to submit that to CMS very soon.
9 And in conjunction with that,
10 Kentucky was recently awarded an opportunity to
11 participate in a learning collaborative for housing
12 supports for individuals with SUD and we're hoping
13 that that learning collaborative will assist us in
14 moving forward some of our initiatives related to the
15 SUD waiver, particularly for individuals who have SUD
16 issues.
17 Once they are receiving that
18 treatment while they're incarcerated, this learning
19 collaborative may help us move them out in to the
20 community with housing supports. So, it's very
21 exciting. We're one of ten states that were chosen
22 to participate in this learning collaborative. So,
23 it's very exciting right now.
24 We also went live with our
25 Electronic Visit Verification Program. That impacts

1 our 1915(c)Home- and Community-Based Waiver Program.
2 So, that went live earlier this week.
3 And I think one of the major
4 topics that I would like to talk about now and have
5 the MAC seriously consider is we have just received
6 from CMS a Core Measures Report on developing child
7 health measures. The report highlights some things
8 that Kentucky is doing really well such as getting
9 children to their primary care providers within one
10 or two years.
11 And we also have some areas
12 that we need improvement on, for example, maternal
13 health.
14 We had some really good marks
15 on our behavioral health delivery system and the
16 number of individuals who are actually seeking care
17 and followup treatment in behavioral health.
18 And also with that, Kentucky
19 Youth Advocates released their Kids Count Book
20 earlier this week, and in that book, they had
21 highlighted some good news for Kentucky which was
22 huge improvement in teen births and the proportion of
23 mothers smoking during pregnancy had decreased. We
24 had record high insurance coverage for kids.
25 But the bad news, the low birth

1 weight remains stubbornly high in Kentucky and
2 coverage caps for (inaudible) children.
3 So, in order to address these
4 issues, of course, the Department is going to
5 continue our targeted and increased outreach to find
6 individuals who are eligible for Medicaid but not
7 enrolled.
8 But I think that the Core
9 Measures and Kentucky Youth Advocates' Kids Count
10 Book highlight, of course, the low birth weights in
11 Kentucky and I think that that's something that this
12 committee could take up and maybe either request
13 data, information, what can we do to start targeting
14 that specific health issue and how can we improve the
15 low birth weight in Kentucky.
16 I know that there' several
17 initiatives that are in play. I think Dr. Theriot is
18 working with a couple of different organizations
19 maybe related to maternal and child health, but I
20 would like for this committee to kind of think about
21 what that means for Kentucky, low birth weight, what
22 does it mean, what can we do, how can we make some
23 improvements in that area.
24 And I think the last thing that
25 I will talk about is we do have a very rough draft of

1 our very first annual report for Medicaid. We hope
2 to get that finalized some time by the end of this
3 year or early next year. I think it will have some
4 really good information in there related to Medicaid
5 enrollment and expenditures and all of the great
6 things that Medicaid has been doing in 2020.
7 So, I'm very excited about that
8 and very thankful to have a great team at Medicaid
9 working on all these important initiatives and look
10 forward to sharing more information with this Council
11 as we move forward. I'll be happy to take any
12 questions.
13 DR. PARTIN: I have a question
14 that related specifically to your report. Has there
15 been any discussion about restricting health care
16 providers' offices? I know that wasn't in the
17 Governor's report yesterday, but I've been receiving
18 questions from providers saying that the Governor is
19 going to say that people can't come to clinics or
20 offices.
21 COMMISSIONER LEE: I haven't
22 heard that yet. I haven't heard anything related to
23 restricting any kind of access to health care.
24 DR. PARTIN: Okay. And, then,
25 my second question is how would you like us to go

1 about your request for improving low-birth-weight
2 babies. Where should we focus our attention?
3 COMMISSIONER LEE: I'm not sure.
4 We know it's an issue. I think we have a lot of
5 experts on this committee and I would look to you to,
6 you know, do you want to request reports specifically
7 from Medicaid or from other areas? What can we do to
8 address this?
9 You're on the Medicaid Advisory
10 Council, and I think that part of the charge is to
11 help us identify these areas and make recommendations
12 on what we need to do and how we can maybe modify the
13 Medicaid Program to address these issues.
14 So, I think I'll leave the
15 format or the process up to the MAC to collaborate
16 together and figure out what we need in order to
17 identify where the deficiencies are and how to make
18 those improvements.
19 DR. PARTIN: Okay. To start,
20 since we must do everything that we do in public,
21 could we request the report that shows where we're
22 getting the problem? That will help us to know where
23 we need to focus our attention.
24 COMMISSIONER LEE: I will send
25 the CMS Core Measures Report out. I'll give that to

1 Sharley and she can send it out to all the TAC
2 members. Also, the KY Youth Advocates' Kids Count
3 Book, we do have that and they have a specific
4 contact information in that report to reach out to
5 with questions.
6 And, so, again, I think this
7 definitely has to be a collaborative effort with the
8 committee, with other stakeholders and the Managed
9 Care Organizations. I do know that this issue is one
10 that the Managed Care Organizations are focused on.
11 They do have certain measures that they're looking at
12 and they have certain programs that they're working
13 on, but, again, we still are lagging in this measure.
14 So, I think that's one we
15 definitely need to focus on. What have we been doing
16 in the past? Is it working? Is it not working? And
17 what do we need to do in the future to improve this
18 measure of low birth weight?
19 DR. PARTIN: Okay. Great. So,
20 we'll look forward to receiving that information,
21 then. Any questions for the Commissioner? Thank you
22 for your report and thank you for your answers to all
23 our questions.
24 We'll move on, then, to the TAC
25 reports. Sharley, do we have an MCO report today

1 from Passport Health Plan by Molina and United
2 Healthcare?
3 MS. HUGHES: We just have from
4 Passport. United Healthcare is not able to attend
5 today.
6 DR. PARTIN: That's what I
7 thought. Okay. Just trying to keep track of our
8 time.
9 So, moving ahead, let's do our
10 TAC reports and just give us the highlights of your
11 reports and, then, any recommendations that you might
12 have. So, we'll start with Therapy Services today.
13 DR. ENNIS: Good morning. Beth
14 Ennis, Chair of the Therapy TAC. We submitted our
15 notes in writing as a request to the MAC. There's
16 several items on there that were informational just
17 so that the MAC was aware.
18 One was a delay in response to
19 a letter from Adult Day Health that was submitted at
20 the beginning of the summer and we've still had no
21 response. I know that the Cabinet is very busy, but
22 that group is becoming increasingly frustrated.
23 Our ask relates to the 99072
24 code, being able to at least bill something for the
25 excessive amounts of PPE that people are needing to

1 use on an ongoing basis as they treat members of the
2 Commonwealth. And I know that it has been discussed
3 as under consideration by the Cabinet, but we are
4 just putting it forward to the MAC to try and support
5 the use of that code in Medicaid in Kentucky. Thank
6 you.
7 DR. PARTIN: Thank you. Any
8 questions? Okay. Primary Care. Podiatry. Physician
9 Services.
10 DR. CAUDILL: This is Mike
11 Caudill with Primary Care and I'm slow, so, look over
12 me if you would.
13 A few things. We had our last
14 meeting earlier this month, on the 13th. One of the
15 things we talked about is the issue with Medicaid
16 Services concerning the wrap payments from 2014, July
17 1, 2014 to the present.
18 There are several issues with
19 that and it has been an ongoing continuous one.
20 Recently, we have had success with the Department in
21 working with the KPCA to try to resolve this, and we
22 certainly appreciate the Department working towards
23 resolving this.
24 And as a TAC, we recommend that
25 that cooperation and working together in good faith

continue to seek a resolution on that.

Also, one of the things that was mentioned were the issues related to potential payment processes that affect FQHCs concerning the DMS Duplicate Logic Number 501 on encounters. Basically, this is same-day visits.

As it works now, if you come in and you're billed a 99213 for primary care and you see the cardiologist the same day who also bills 99213 and perhaps a psychiatrist along with their associated ancillary services that also bills 99213, then, currently, the second and third visit is considered duplicate and there's no payment on that.

This is a discussion that is now ongoing. Lee Guice has stated in one of our meetings that the Department researched the possibility of either exempting provider types 31 and 35, FQHCs and RHCS, from this logic or adding rendering provider NPI to the logic.

We are expecting the Department to follow up at our January meeting with an update on Ms. Guice's statement.

And let me go off a little bit and say that I'm aware that we are a border clinic housed in Kentucky and we're currently working with

1 Virginia Medicaid to be certified over there. And
2 under their guidelines, then, what they do is they
3 allow you to bill for the first visit, and, then,
4 subsequent visits on the same day are billed at half
5 the PPS rate.
6 And I've been told in Colorado
7 that they separate it out into three different
8 brackets of dental, behavioral health and primary
9 care that would allow separate payments if they fall
10 in those three or a combination of those three areas.
11 So, I think this is an area
12 that is a great concern. We try very hard in our
13 organization to do same-day services and we may do
14 dental, behavioral health or multiple other things,
15 pulmonary which is considered primary care or
16 infectious disease and still just be paid for one
17 service.
18 And, then, going on, let me say
19 that the Primary Care TAC and myself personally, we
20 certainly agree with the Chair's earlier statement
21 today that the distant sites for telehealth should
22 include telephone-only services. As a matter of
23 fact, we have a recommendation to that point and
24 allow me to read that recommendation.
25 The committee recommends the

1 Kentucky Department of Medicaid Services work to
2 allow FQHCs and RHCs to act and bill as distant sites
3 for telehealth services post public health emergency.
4 And let me add to that, that in
5 our areas, and I'm located in the coalfields of
6 Southeastern Kentucky, we have problems with
7 communications of being adequate to be able to do
8 Internet visits through telehealth, and we have a lot
9 of older people and people with chronic diseases and
10 disabilities that find it difficult to use this
11 "modern technology".
12 And it has really helped and
13 made a big difference in being able to do telephone
14 visits with our people and we certainly hope that
15 does continue.
16 And, lastly, we have approved
17 our 2021 meeting dates. We have been meeting on a
18 regular schedule by special meeting through Zoom for
19 2020, but going forward, there will be regular
20 meetings but will still be by Zoom.
21 We will be meeting the second
22 Friday in front of the MAC's meeting, and our dates
23 at this time for 2021 would be January 8th, March
24 12th, May 14th, July 9th, September 10th, October 8th,
25 and December 10th. And I'm not sure exactly how I

1 got those last two in there, but, anyway, we'll be
2 meeting the second Friday of the month in front of
3 the month that the MAC meeting takes place, and
4 that's my report, Madam Chair.
5 DR. PARTIN: Thank you. So, I
6 have a question and a comment. Are you making a
7 recommendation that same-day visits for specialty
8 care should be reimbursed even if the patient has
9 seen a primary care provider that day?
10 MR. CAUDILL: Ma'am, while I
11 certainly believe that, that recommendation has not
12 been voted on by the TAC and I would not make it on
13 my own.
14 The recommendation from the TAC
15 is the committee recommends that the Kentucky
16 Department of Medicaid Services work to allow FQHCs
17 and RHCs to act and bill as a distant site for
18 telehealth services post public health emergency.
19 I certainly would like for the
20 Department to look into these possibilities as an
21 alternate reimbursement from what is the current
22 status.
23 CHAIR PARTIN: Okay. So, having
24 said that, coming from the MAC, if the MAC approves,
25 I would like to make that recommendation, that DMS

1 look at reimbursing for other visits that are
2 specialty. I certainly could understand why the
3 Department wouldn't want to pay for two primary care
4 visits in the same day; but if a patient is coming
5 for a behavioral health visit as well as a primary
6 care visit and perhaps needing to see a cardiologist
7 or some other specialty, I think it's important for
8 those specialties to be able to be reimbursed for
9 their services or whoever gets their bill in first, I
10 guess.
11 And, again, I can speak from
12 the rural perspective. Transportation is a big
13 problem for people in the rural areas, particularly
14 for elderly people but some young people as well.
15 And, then, we also have people
16 who are working but who are also eligible for
17 expanded Medicaid who can't just take off work all
18 the time. And, so, they try to make their visits all
19 in one day so that they don't have to miss work.
20 And, then, many of these people are working in low-
21 paying positions and they are not able to get days
22 off. So, it makes it very hard for them to make
23 multiple appointments on multiple days.
24 So, I would request that the
25 Department look at that and come back to us with some

1 kind of response.

2 MR. CAUDILL: Thank you.

3 DR. PARTIN: Does anybody else

4 have anything, any questions? Okay. Physician

5 Services.

6 DR. McINTYRE: This is Dr.

7 McIntyre, Vice-Chairman of the PTAC. We didn't meet

8 this quarter.

9 DR. PARTIN: Okay. Thank you.

10 Pharmacy.

11 MR. POOLE: Thank you, Madam

12 Chair. This is Ron Poole. I'm the Chair of the

13 Pharmacy TAC group.

14 We have had two meetings. The

15 statute, Senate Bill 50, allows for Kentucky

16 pharmacists to create and suggest a payment

17 methodology to the Kentucky Department of Medicaid

18 Services for implementation and serving our Kentucky

19 Medicaid patients.

20 Just reviewing quickly, we

21 looked at several national studies and one state

22 study, but the national study, the Myers & Stauffer

23 study, basically went through and evaluated all

24 across the nation all the different fee-for-services.

25 And just for educating people,

1 the cost of dispensing includes all activities needed
2 to prepare the product for dispensing, not including
3 the actual cost of the product but all ancillary
4 costs such as labor, supplies, rent, insurance,
5 utility costs, IT costs, and additional costs.
6 The current professional
7 dispensing fee at $10.64 was what Myers & Stauffer
8 came up with for the fee-for-service methodology that
9 was derived from reviewing cost-of-dispensing
10 performed in other states.
11 The requirements for
12 professional dispensing fees included within CMS-
13 2345-FC allows State Medicaid Programs to set
14 professional dispensing fees based on the results of
15 either its own cost-of-dispensing survey, the results
16 of cost-of-dispensing surveys in other states, or on
17 results of national surveys.
18 I want to point out that that
19 particular study was based off of data from January,
20 2017 to December 31st, 2018.
21 Another study, the Optimum
22 Study that was done for the Kentucky Independent
23 Pharmacists Alliance developed an analysis to review
24 the state Medicaid's prescription costs using the
25 National Average Drug Acquisition Cost for

1 reimbursement plus $10.64 dispensing fee per script
2 using claims actually from 2016.
3 And, then, we looked at the ABT
4 Associates' 2020 Cost-of-Dispensing Study that was
5 done in January of 2020 that was commissioned by the
6 National Association of Chain Drugstores, National
7 Association of Specialty Pharmacy and the National
8 Community Pharmacists Association. These estimates
9 of the cost of dispensing and evaluation in this
10 study were from 2018.
11 Their mean overall cost of
12 dispensing per prescription was $12.40 with 58% of
13 that cost being made up just on labor, on payroll.
14 The mean cost of dispensing for drugs covered by
15 Medicaid fee-for-service was $12.45.
16 So, in lieu of everything we
17 reviewed and went over, and as you can tell, what we
18 were going over was actually dated, and I will point
19 out that the lowest-of-reimbursement logic that is
20 associated in our recommendation using the National
21 Average Drug Acquisition Cost, with the acronym noted
22 as NADAC, the Wholesale Acquisition Cost, noted as
23 the WAC, the Federal Upper Limit, noted as the FUL,
24 and the usual and customary price of the pharmacy,
25 three out of four of those are dealing with aged

1 data. So, all those other data banks on pricing, the
2 NADAC, the WAC and the FUL are based off of data
3 that's in the past.
4 So, the TAC presented a motion
5 and it passed and it is recommended to the MAC and to
6 the Department for Medicaid Services for our
7 Department for Medicaid Services to request that the
8 Centers for Medicare and Medicaid Services approve
9 the lowest-of-logic ingredient cost as the NADAC, the
10 National Average Drug Acquisition Cost, the FUL,
11 Federal Upper Limit, the WAC, the Wholesale
12 Acquisition Cost, or the usual and customary price,
13 whichever again is the lowest of logic, and a
14 dispensing fee rate of $10.64 as the floor for
15 reimbursement for Kentucky Medicaid prescriptions
16 filled under managed care and all pharmacy types.
17 340B-purchased drugs dispensed
18 by a pharmacy should not have the 340B ceiling price
19 included in the lowest of logic. Maximum Allowable
20 Cost will not be included in the lowest of logic.
21 Additionally, that the DMS send
22 the request to CMS in a timely manner since Senate
23 Bill 50 requires that the Cabinet sets reimbursement
24 rates to be used in conjunction with a single state
25 Pharmacy Benefit Manager.

1 Do I have any questions on that
2 particular motion that passed?
3 DR. HANNA: I don't have any
4 questions. I just wanted to reiterate the importance
5 of this and that it move forward as quickly as
6 possible. I think it's very important.
7 Senate Bill 50 does say that
8 we'll have this done by January 1, 2021. I work with
9 a lot of pharmacies and this is extremely important.
10 And these pharmacies out in many of these areas, they
11 have to be able to be reimbursed at a rate which
12 continues to allow them to practice in their
13 communities. And, so, it's extremely important.
14 MR. POOLE: And just to
15 reiterate a little bit of what Cathy said - and these
16 are my personal statements here - we encourage, along
17 with our legislators encourage, for the Kentucky
18 Department for Medicaid Services to implement this
19 reimbursement methodology as soon as possible for the
20 stability of all of our Kentucky pharmacies.
21 I would definitely think that
22 given the large savings that other states have
23 reported, that our Kentucky Department for Medicaid
24 Services would like to realize these savings sooner
25 than later. Most of the states that have realized

1 savings of a large nature had a complete carve-out of
2 pharmacy benefits back to fee-for-service.
3 So, if large savings aren't
4 shown in this first year, I would encourage the
5 Department for Medicaid Services look at the MCO
6 model that needs to be examined.
7 In our second motion, we had a
8 request that the Kentucky Department for Medicaid
9 Services work with pharmacy organizations to develop
10 payment models for existing and future developed
11 clinical protocols and services to be approved by CMS
12 for a clinical reimbursement model.
13 Does anybody have any questions
14 for me?
15 Dr. Partin, you made the
16 comment about the pharmacists needing to report the
17 vaccinations to KYIR and that is something that we're
18 currently working on, and I really think that the
19 COVID vaccination is going to make that mandatory and
20 everybody is going to have that avenue ready to go.
21 However, I do want to point out
22 that in order for pharmacists to practice to the best
23 of our abilities, we need to be informed of any drug
24 therapy changes.
25 When you have patients seeing

1 hospitalists in a hospital, a primary care physician
2 or a nurse practitioner, a physician or nurse
3 practitioner specialist, in addition to patients
4 using polypharmacy, you can see where pharmacists can
5 miss out on important information.
6 So, not only is this is a
7 current problem but this is has always been a problem
8 in my thirty years as a practicing pharmacist.
9 So, I would hope that we could
10 encourage our prescribers to please inform the
11 pharmacist of any kind of drug therapy changes
12 because juggling between all the practitioners now
13 that one patient can have nowadays with everybody
14 going to be a specialist along with their primary
15 care physician or nurse practitioner, it's very
16 difficult to keep up.
17 And, then when we do interview
18 our patients and question them, many times they can't
19 remember when they're told during a brief visit with
20 a particular practitioner.
21 So, I just encourage anything
22 that can help with either all of us finally getting
23 on E-Health and being able to share information or
24 just practitioners aware of the problem. Thank you.
25 DR. PARTIN: Thanks, Ron, and

1 it's good to see you.

2 DR. POOLE: Good to see you,

3 too.

4 DR. PARTIN: I couldn't agree

5 more with what you just said about communication, and

6 that's a problem across the board, not just with

7 pharmacists. I have that problem all the time -

8 well, I shouldn't say all the time but frequently

9 with patients who are seeing specialists.

10 They're prescribed medication

11 and the specialist is not communicating with the

12 primary care provider and the primary care provider

13 doesn't know what medications have been prescribed.

14 And when you ask the patients, they say, oh, it's the

15 blue pill or the white pill and they don't even know

16 what the medicine is for many times.

17 So, if there would be a way to

18 communicate that. I try when I electronically

19 prescribe, if I'm discontinuing a medicine, I put it

20 in the pharmacy note that I'm discontinuing a

21 medicine and starting another one, but I know that's

22 just a drop in the bucket. That doesn't get to the

23 major part of the big problem, but thank you.

24 MR. POOLE: You're welcome.

25 Thank you.

1 DR. PARTIN: Optometry.

2 DR. COMPTON: Thank you. This

3 is Steve Compton, a member of the Optometric TAC. We

4 met on November 5th for the first time since February

5 via Zoom.

6 We talked about who the new

7 subcontractors would be for the----

8 MS. HUGHES: I know they met.

9 Dr. Compton?

10 DR. COMPTON: Our main -

11 Sharley, can you hear me? Can anyone hear me?

12 DR. PARTIN: I can hear you.

13 DR. COMPTON: Keep going?

14 DR. PARTIN: Yes.

15 DR. COMPTON: We had it

16 confirmed yesterday who the subcontractors are. And

17 as soon as we get credentialing information, we'll

18 get that out to our members along with that side-by-

19 side document that we talked about earlier today.

20 The rest of the meeting was

21 spent talking about billing issues and a number of

22 them have been resolved. We brought up a few more on

23 Medicare and Medicaid crossovers, that sort of thing,

24 and I think we're working toward getting those

25 resolved. They're just little glitches that need to

1 be worked out in the software.

2 And, then, we talked about

3 credentialing with DMS, that we're hoping we can get

4 our Board of Examiners just to upload the license

5 information every year straight to DMS so that each

6 individual practitioner doesn't have to scan, email

7 and all that sort of thing, just to make the process

8 a little more efficient, and we set our meeting dates

9 for 2021. We have no recommendations and that's the

10 end of my report.

11 DR. PARTIN: Thank you. Nursing

12 Services did not meet. Intellectual and

13 Developmental Disabilities. Hospital. Home Health.

14 MS. STEWART: We haven't met.

15 We do have a meeting scheduled in December where we

16 will establish our meeting dates for next year.

17 DR. PARTIN: Thank you. Nursing

18 Home.

19 MR. MULLER: John Muller. We

20 did not meet but I do have a couple of comments I'd

21 like to lead in, if that's all right.

22 In the nursing homes, you're

23 likely aware that 60% of the COVID fatalities across

24 the state have occurred, unfortunately, in nursing

25 facilities, and our residents are depending on our

1 ability to prevent the virus from coming in.

2 As Governor Beshear said the

3 other day, though, if it's in the communities, it

4 will get into the nursing facilities.

5 From the Medicaid end, back in

6 April, the Cabinet and Medicaid put on a $270-a-day

7 rate add-on for Medicaid beneficiaries who tested

8 positive only for their time of positivity which

9 affects a very, very small amount of people, and they

10 also extended the bed hold amount from fifteen days

11 to thirty days, as well as covered our mandated

12 surveillance testing protocols.

13 So, those have been helpful but

14 we're in a real predicament. The PPE continues to

15 cost. We have to pay our staff more, and I'm sure

16 you all want us to pay them more, but we've had to

17 pay our staff more to show up.

18 So, some providers, good news.

19 Some providers have been able to access small

20 business loans. We have received a substantial

21 amount of federal CARES Act money but that money is

22 rapidly running out.

23 So, what we're worried is the

24 next six months of time. You all see the rates. You

25 all see the hospitalizations which we're really an

1 important part of the whole continuum of care.
2 Our next six months, we need to
3 just continue to have the Department of Medicaid to
4 talk about what possibly can be done about the rates.
5 So, I'd like to do a thank you,
6 though, for the Commissioner's action. We only have
7 one transportation, CON transportation provider here
8 in Northern Kentucky. As Dr. Partin, mentioned,
9 transportation is difficult.
10 Whenever a patient has turned
11 COVID positive, our transportation options vanish.
12 So, they will not take COVID-positive patients to
13 dialysis visits, if you can imagine this. So, it
14 creates an emergent situation.
15 We filed that with the
16 Cabinet's Long-Term Care Task Force. They got that
17 to the Commissioner's Office and I'd like to thank
18 you. A member of the Kentucky Transportation Cabinet
19 called us the other day and is directly working with
20 the Medicaid contractor to get them to transport
21 COVID-positive patients to essential medical
22 appointments. So, thank you for that. We really
23 needed that to come to fruition.
24 And just finally another word
25 because of the venue here, all insurance forms are

1 going up - property/casualty, professional and
2 general liability. The primary reason, as always,
3 they say you practice in Kentucky and there are no
4 limits on any type of a reasonable tort reform.
5 This year also, there is a
6 pandemic exclusion. So, all four companies that
7 wrote a bid, all of them are excluding anything
8 related to the pandemic. So, that will be an
9 interesting thing to work out over the next few
10 years.
11 So, our personal rates
12 increased more than $595 per bed. So, you can do the
13 math. We have six hundred some beds, but across the
14 state, there's 27,000 nursing home residents in those
15 beds which, pertinent to this, Medicaid might as well
16 send the money directly to the out-of-state insurance
17 companies - might as well directly send that to them.
18 So, other than that, we will
19 keep up the fight in the nursing facilities and thank
20 you, guys, for all your support in the medical
21 community. Thank you.
22 DR. PARTIN: Thank you.
23 Commissioner, when you said you couldn't hear me, did
24 you hear the part where I was talking about the
25 reimbursement for multiple visits on the same day?

1 COMMISSIONER LEE: I did hear
2 that part. After that, there was a little bit that
3 cut out. It must have been my Internet connection
4 but I did hear the comment you made about multiple
5 visits.
6 DR. PARTIN: Okay. Great.
7 Thank you. Just checking.
8 MS. HUGHES: Everybody, I
9 apologize. I just got kicked out of my work
10 computer. So, I don't know what happened, but it
11 looks like you all were able to keep going on, but
12 that may have caused some issues, too.
13 DR. PARTIN: Okay. Well, as far
14 as the minutes go, has that been----
15 MS. HUGHES: I think Terri is
16 still on here, so, I think that's fine.
17 DR. PARTIN: Okay. Dental.
18 Consumer Rights and Client Needs. Well, I had a
19 question for you all, for Consumer Rights and Client
20 Needs; but since we don't have anybody representing
21 that, we'll hold that until next time.
22 DR. BOBROWSKI: This is Dr.
23 Bobrowski. I'm sorry. I thought I had unmuted but I
24 didn't for the Dental report.
25 DR. PARTIn: Okay. Go ahead.

1 DR. BOBROWSKI: We did not have
2 a TAC meeting, but from listening to the other folks,
3 other TAC members that we've been in conversation and
4 want to reiterate some of the same problems with PPE
5 and the higher cost of PPE. Some places have gone
6 down a little bit in price but a lot is still very
7 significantly high fees for PPE, and with the lower
8 reimbursement rates for Medicaid, it's tough to make
9 a go and the dentists are feeling this financial
10 pinch.
11 We'll have a TAC meeting pretty
12 soon and I'll give you a better report. Thank you.
13 DR. PARTIN: Thank you, Dr.
14 Bobrowski. PPE is a problem across the board. I
15 know personally, we are reusing our masks for not
16 days, weeks, and we are washing gowns that are
17 supposed to be used once, and we're even using the
18 same face shields that we've used from day one.
19 We're just cleaning them off with alcohol or bleach.
20 So, it's a big problem.
21 Children's Health.
22 MS. HUGHES: They met yesterday,
23 Beth. I don't know that anybody is here, though.
24 DR. PARTIN: Okay. Behavioral
25 Health.

1 MS. SCHUSTER: I'm here. So, I
2 have all kinds of time, I guess, right?
3 DR. PARTIN: Well, a little bit
4 of time.
5 MS. SCHUSTER: The Behavioral
6 Health TAC met on November 4th and we had a quorum of
7 all six of our TAC members, and we were delighted to
8 have representatives from DMS and the Medical
9 Director from the Department for Behavioral Health,
10 Developmental and Intellectual Disabilities, and we
11 thank Sharley for making it happen. This is our
12 second one in a row and everybody is getting used to
13 it and I think it's working very well, thanks to
14 Sharley.
15 Commissioner Lee was unable to
16 be at the meeting but we did have representation from
17 the Cabinet and they indicated that the suspension of
18 prior authorizations for behavioral health services
19 would continue which has been a godsend, quite
20 frankly.
21 I think I've spoken before
22 about the importance of what we call targeted case
23 management for our people with severe mental illness
24 and substance use disorders, and that's really the
25 kind of hand on the shoulder, making sure people get

1 to their appointments and get connected with
2 services. For a while, the MCOs were making it,
3 quite frankly, very difficult to get those services
4 for our people. So, we're delighted that that is not
5 happening at this point.
6 We had some really exciting
7 discussion. I know most of the TAC meetings are not
8 exciting, but the Behavioral Health TAC has
9 recommended for years - for those of you who are on
10 the MAC, you've heard this recommendation from me for
11 years - that we have a single formulary in Medicaid.
12 One of the most important
13 things for our folks particularly with severe mental
14 illness but also substance use disorders is access to
15 the right medication and the right dosage at the
16 right time. And with five different MCOs, five
17 different formularies, five different PDL's, five
18 different rules for prior authorization, prescribers
19 were finding it extremely difficult.
20 So, we spent a good bit of time
21 talking about the implementation of Senate Bill 50
22 which was passed in this last General Assembly, and
23 we are very grateful that Dr. Jessin Joseph, Director
24 of the DMS Pharmacy Section, was with us. He was
25 very informative and listened to comments.

1 We had Dr. Pinto, a longtime
2 psychiatrist at CommuniCare Mental Health Center in
3 Elizabethtown who talked about the need to have the
4 long-acting injectables as part of the formulary, and
5 Dr. Brenzel also from the Department for Behavioral
6 Health also had been working with Medicaid.
7 And I think in the end, we are
8 extremely pleased with the addition of the long-
9 acting injectables and the other psychotropic
10 medications and also making those protected classes
11 so that people that are on their current medications
12 will not have to change those when the formulary
13 changes.
14 So, I just cannot thank Dr.
15 Joseph enough or Medicaid for being so cooperative
16 and working with us.
17 Stephanie Bates was at the
18 meeting and we got the update on the copays and that
19 committee meeting will be this afternoon, also the
20 open enrollment information.
21 We still come back to the need
22 for a single medical necessity criteria. Nina
23 Eisner, who has been on the MAC, has raised this
24 issue over and over again. And we were told that the
25 new contracts with the MCOs will require them to put

1 their medical necessity criteria on their website
2 which I think is a step forward. I’m not sure all of
3 us can interpret what those medical necessity
4 criteria actually are doing but at least it’s
5 certainly a step forward in terms of transparency.
6 We talked about telehealth and
7 about how helpful it has been, particularly in
8 behavioral health situations. And I would just
9 reinforce the previous discussion among the MAC
10 members about keeping all the platforms available
11 including telephonic.
12 As Dr. Partin pointed out,
13 there are so many people that don’t have access to
14 Internet coverage, and we have found that telephone,
15 checking in with people has subverted some crisis
16 situations and probably saved some lives, quite
17 frankly.
18 We also had a presentation from
19 Leslie Hoffmann who has done an excellent job in
20 preparing the 1115 waiver amendment to provide
21 substance use disorder services for individuals who
22 are Medicaid eligible and incarcerated, and there was
23 good back and forth in that discussion. So, we’re
24 waiting to see what the final submission looks like.
25 We also had a report on some

1 recommendations from the acquired brain injury group
2 and those will be given at the Health and Welfare and
3 Welfare Committee meeting this afternoon as well.
4 We didn't have any new
5 recommendations for the MAC, but we did want to go on
6 record as again thanking DMS for their active
7 participation in our meetings, for the continued
8 suspension of prior authorization for behavioral
9 health services, and for the responsiveness of the
10 DMS Pharmacy Department to meet the needs of Medicaid
11 recipients with behavioral health issues.
12 We set our meeting dates.
13 We're moving to the first Wednesday of the month in
14 order not to conflict with the Children's Health TAC.
15 And I think when I submitted my
16 report, Sharley, I said I was also putting those
17 dates in the email but I forgot to do that. So, I
18 will send those to you.
19 That concludes the formal
20 report. I would just like to comment on the report
21 that Commissioner Lee made around low birth weights
22 and I would like to ask that the Behavioral Health
23 TAC be a part of the study and discussion on low
24 birth weights.
25 There is considerable research

1 that shows a correlation with a mother's stress and
2 depression and resulting low birth weight in their
3 babies, as well as racial differences that should be
4 considered.
5 So, I would request that our
6 TAC and maybe all the TACs be sent that report from
7 CMS. I think we would all find that very
8 interesting, but we would certainly like to be at the
9 table and to be of whatever help we can be to the MAC
10 as you all move forward with trying to address the
11 low birth weights in Kentucky's babies.
12 That concludes my report. I'm
13 happy to answer any questions.
14 DR. PARTIN: Thank you. I think
15 what we'll do if there's a broad interest by some of
16 the other TACs, then, at our next meeting agenda, I
17 will put that on the agenda for the TACs to speak to
18 that so that we can have that feedback directly to
19 the MAC in addition to whatever the MAC comes forward
20 with.
21 And Sharley is moving us right
22 along here to the MCO report from Passport Health
23 Plan by Molina. Before we start that, Sharley,
24 should we add United Healthcare to the agenda for the
25 next meeting?

1 MS. HUGHES: Yes. We can do
2 that, Beth.
3 DR. PARTIN: Okay. So,
4 everybody, United Healthcare will be on the agenda
5 for next time.
6 MS. HUGHES: Just to let
7 everybody know, I think they're in the middle of
8 readiness review today is why they're not able to be
9 here.
10 DR. PARTIN: Okay. So, welcome,
11 Passport Health Plan by Molina. Go ahead with your
12 report.
13 MR. SADLER: Thank you very
14 much, Elizabeth. This is Ryan Sadler.
15 Good morning, everyone, and
16 thank you so much for having us. We appreciate the
17 opportunity to be here today and present to you guys.
18 My name is Ryan Sadler, and I'm
19 the CEO and Plan President for Passport Health Plan
20 by Molina Healthcare.
21 We'll do a little bit of an
22 introduction here in terms of the organization and
23 then we'll get into some of the substances on the
24 agenda provided.
25 To start with, I just want to

1 take a moment to remember the member. And one thing
2 we challenge our team to do every day is to really
3 focus from an insurance perspective but from an MCO
4 perspective.
5 While you guys are on the front
6 lines every day treating these patients and seeing
7 our members, taking care of the people on the ground
8 on the front lines, our challenge is to make sure
9 we're thinking about that interaction each and every
10 day, right?
11 So, we need to do everything we
12 can not to get in your way and make sure that care is
13 delivered in the right place at the right time for
14 our members and for your patients.
15 To start with, again, the way
16 that I like to tee things up with our team is to
17 remember everything we're doing has a connection to
18 the patients that you serve.
19 So, this is just a story of an
20 example where one of our members had called up during
21 COVID and was scared to death about food insecurity.
22 As you see, it was somebody out in Williamstown and
23 living with COPD and lung cancer, scared to leave the
24 house, quite frankly, and in Williamstown, they did
25 not have delivery of groceries.

1 And, so, when the team realized
2 this and having received that call, they made some
3 phone calls to local grocery stores, found a local
4 grocery store owner who ultimately took it upon
5 themselves to deliver the groceries even though they
6 don’t have a delivery service, right? We put the two
7 together, got it resolved. It’s a little thing but
8 it made all the difference in the world for that
9 patient.
10 Because of our interaction with
11 the members in the way that we have it, this is an
12 example where they may not pick up the phone
13 necessarily and call you. So, hopefully, this is
14 value added and (inaudible) to the mission, and we’re
15 all here to do which is to serve our members, right?
16 As we talk about it, here is
17 the agenda we’ll cover just to give you a little
18 flavor of who we are and what we’re doing. I’ll save
19 the introductions for when the folks come on the line
20 and speak, but just so you know, these are some of
21 the topics that we’ll be covering here in the
22 remaining slides.
23 So, for your awareness, I
24 wanted to make sure that you have seen and are seen
25 sort of our new brand and logo and talk a little bit

1 about, quite frankly, the transaction that Molina
2 Healthcare parent company acquiring a health plan
3 business through Passport Health Plan and bringing
4 the two together in really what I believe is the best
5 of both worlds and that is, as you see at the bottom,
6 Passport Health Plan by Molina Healthcare being
7 better together and giving you and, quite frankly,
8 our members more.
9 The whole idea here is what
10 we're levering is the 22-year historical experience
11 of on-the-ground sort of experts in the Louisville
12 but throughout the Commonwealth area together with
13 sort of the infrastructure, a national best practice
14 that comes with the Molina Healthcare organization.
15 And, so, as we bring those two
16 together, it allows us to combine both people and
17 systems and present really what is going to look and
18 feel different moving forward but with the focus,
19 quite frankly, being on this continuity for members
20 and providers from pre- and post, if you will.
21 So, what you will see here is,
22 of course, our network looking and feeling very
23 similar despite the sort of systems and underlying
24 processes that were changed related to the
25 infrastructure of Molina.

1 So, what we were trying to do,
2 quite frankly, is make the transition into a smooth
3 contract, the new 2021 contract and beyond as
4 seamless as we can so that hopefully really what is
5 going on is mostly behind the scenes and is as
6 seamless as possible not only for you guys as
7 providers but also for our members.
8 At the end of the day, and I
9 think we share this vision with Commissioner Lee, at
10 the heart of everything we're doing is the providers,
11 right? Without you, we have no services to provide
12 to our members.
13 So, in order for us to take
14 care of our members, we acknowledge that we've got to
15 take care of you as providers. So, as you see here
16 on this slide relative to our mission, our members
17 are at the core of everything we do; but key to that
18 whole process are these associated stakeholders, not
19 least of which is providers.
20 So, I get it that it's not
21 always going to be free time and recess, right? This
22 is work. This is hard work. We're all in the
23 trenches, but my sort of commitment to you relative
24 to the providers is that we're going to work with you
25 to make sure we're transparent and, then, we deliver

1 on what we say we're going to deliver.
2 Again, it's not always going to
3 be perfect, right, but my intent here is that you
4 find us as easiest to work with. Now, we all have to
5 push and pull in the processes; but as long as we're
6 up front, transparent and you have some reasonable
7 certainty of how we're going to be able to work
8 together, then, I think we can accomplish a lot of
9 great good together.
10 Clearly, this is where we're
11 trying to focus on our value proposition not only to
12 the Commonwealth but to the providers and to our
13 members. We want to be low cost, and what I mean by
14 that, quite frankly, is low cost to you in the sense
15 that our goal here is not to nickel and dime you. As
16 I always say, it costs me a nickel to kind of keep a
17 dollar out of your pocket, if that makes sense.
18 So, what I mean is I want to
19 pay you right the first time and every time because
20 that's less headache and administrative costs for
21 both of us, right? It does me no good to avoid the
22 appropriate payment or the appropriate prior
23 authorization and processing the like.
24 The goal is to get it right on
25 both sides so that we can streamline the process as

1 much as we can. Again, doing those kind of things
2 and being operationally efficient on both sides of
3 the ledger I think hopefully positions us to be the
4 MCO and partner of choice for all of you.
5 Just to give you a sense, the
6 next couple of slides here give you some perspective
7 on the parent organization, where we are, where we
8 operate, and just to drive home the fact that we do
9 have a real expertise in this space. This is what we
10 do.
11 So, as you see on the slide,
12 88% of our business is, in fact, through and through
13 Medicaid. And what that means is that we have a lot
14 of experience in a number of markets in order to make
15 sure that we're providing the best service not only
16 to our members but also to you as providers.
17 This gives you some breakdown
18 in terms of the different populations within that
19 Medicaid portfolio, and it also lays out some of the
20 other states in which we operate in size of
21 membership.
22 And, so, this is relevant
23 although a little dated a few months ago, but this is
24 relevant for a couple of reasons. One is I just want
25 you to be aware, as an organization, we are among the

1 bigger MCOs and businesses within the parent
2 organization. We're not the biggest, certainly not
3 the smallest, but I just raise it because we're
4 getting all of the resources and attention we need
5 from our corporate partners to help make sure we're
6 successful, and I think it's relevant because it
7 matters what happens here in Kentucky. And, so, it's
8 got a lot of attention at our corporate level and
9 down.
10 The next slide speaks to our
11 One-Stop Help Centers, and there's been a number of
12 conversations about this and some interest from some
13 of the providers.
14 I think what I will do here is
15 turn it over to John Wiley and Melanie Claypool.
16 John can introduce himself briefly, but he is our new
17 Vice-President of Network. So, he's a welcomed
18 addition to the Passport team and I think he will
19 provide a lot of value for us as we move forward.
20 So, welcome, John, and please introduce yourself.
21 MR. WILEY: Thanks, Ryan. Yes,
22 John Wiley, the new Vice-President of Network
23 Strategy and coming here with a rich background in
24 Medicaid, Medicare and commercial but most recently
25 in Medicaid in the various states here in the Midwest

1 including the Commonwealth, Ohio, West Virginia. And
2 I'm very pleased to join and be a partner with you
3 all, and I'm very lucky and fortunate to have the
4 staff that I have that have moved over or will be
5 moving over from Passport.
6 And to that end, Melanie
7 Claypool is going to walk us through the slides.
8 And, again, it's a pleasure to meet you all and I'd
9 like to mirror exactly what Ryan says. This is very
10 important that we have that relationship and I look
11 forward to working with you all and making this very
12 successful. So, again, thank you for having me.
13 It's a pleasure to be here.
14 MS. CLAYPOOL: Thank you, John.
15 Thank you, Ryan. My name is Melanie Claypool. I'm
16 the Director of the Provider Services Department at
17 Passport and have been with Passport for many years.
18 So, we're delighted to join with all of this great
19 experience and talent to move our provider network to
20 the next level. We're very thrilled to be aligned
21 now with Molina.
22 Ryan had showed across the
23 nation all the different states that Molina is doing
24 Medicaid work on a daily basis. And, so, now you may
25 have noticed that green State of Kentucky. And what

1 we're doing is going beyond the centralized area of
2 Louisville that we've been in for so many years and
3 then moved to statewide in 2014 and we are setting up
4 these six One-Stop Help Centers which are going to be
5 so dynamic and so provider friendly and member
6 friendly to have folks in place that are there who
7 will be able to talk to your patients and our
8 providers once COVID lifts.
9 We're not doing it right away,
10 but they are strategically located across the
11 Commonwealth and construction is underway actually in
12 Covington, in Hazard and Bowling Green and Owensboro
13 and we have additional lease arrangements in the
14 works for Louisville and for Lexington.
15 As I mentioned, the offices are
16 very easily accessible and they offer providers
17 places for meetings and trainings. You notice the
18 telehealth capability there that we had talked about
19 earlier in our conversations already today. And our
20 Provider Service Representatives - we're going to
21 call them the Senior PSR's - they're my staff and I'm
22 so proud of them all. I'll introduce you to them in
23 a minute.
24 Once these COVID restrictions
25 are lifted, we're going to have many face-to-face

1 contacts and these relationships that have been
2 established for many, many years will be continuing,
3 of course, on a virtual basis today and in person
4 soon.
5 Our Provider Services
6 Representatives offer exceptional knowledge and
7 professional services to the providers in the
8 Commonwealth. I'm hoping that every person that's on
9 the phone today knows your Provider Service Rep. And
10 if you don't, please let me know because they are
11 assigned to every provider in the Commonwealth that
12 we work with.
13 On the recent 2020 Provider
14 Satisfaction Survey, our Provider Relations Reps
15 demonstrated the highest score on that survey and
16 that question was, the representative's ability to
17 answer questions and resolve problems. We're very
18 proud of that and we take it very, very seriously
19 that we are in the know and can educate you on any
20 changes as they come down the pike.
21 Our team is composed of reps.
22 Some of them have been in the Department for over
23 fifteen years. We live throughout the entire state
24 and they're going to be servicing those One-Stop Help
25 Centers as we've discussed. We've demonstrated for

1 many, many years that our reps make countless site
2 visits. We're responsive to phone and email
3 inquiries within two business days and we provide
4 education and training as they are the subject matter
5 experts.
6 This week, we are having
7 webinars and I hope each of you have been able to
8 sign up online. We've had over 400 registrations
9 just for the two days that we've offered them this
10 week. We're offering a dozen webinars from now to
11 the end of the year.
12 And, then, in January, we're
13 offering refresher webinars and many of those are
14 going to be provider-specific. So, as you've gone
15 through your reports for behavioral health, for
16 example, we're going to have a specific webinar just
17 for those provider types and you can phone in, ask
18 questions and make sure that this transition is very
19 smooth for you.
20 As you can tell across this
21 map, Passport by Molina has contracted with many,
22 many hospitals across the Commonwealth - you can see
23 that it's totally green - and we're looking forward
24 to the same and even better, robust network for 2021.
25 We already have established a

1 very strong hospital network throughout the
2 Commonwealth, and all of them are contracted with the
3 exception of Owensboro but everybody else is right
4 now, and we have confirmed we have 100% hospital
5 adequacy.
6 MR. SADLER: And, Sharley, could
7 you move to 12.
8 MS. CLAYPOOL: Thank you.
9 MS. HUGHES: I apologize.
10 MS. CLAYPOOL: I won't repeat my
11 comments, I think everybody heard. We can go to the
12 next one. This should be the one that says Join our
13 Network. For many, many----
14 MR. SADLER: I'm sorry, Melanie.
15 It just might be a good point of clarification, your
16 comment about Owensboro not being in the network.
17 Do you just want to clarify between 2020 versus 2021?
18 MS. CLAYPOOL: Absolutely, yes.
19 Of course, they are in the network right now until
20 12/31 of 2020 and we continue to work with them on a
21 daily basis, yes.
22 MR. SADLER: Thanks. I just
23 wanted to make sure we call that out. So, as we
24 transition to our new contract in 2021, what we have
25 attempted to do is contract with brand new paper.

1 So, obviously, the legacy
2 Passport network has been in existence for many, many
3 years. What we've done is we've built a new network
4 and formed completely by the legacy Passport network.
5 So, all of the hospitals, for
6 example, are on the new paper, the new network. And,
7 then, what we've done is we've offered every provider
8 that we didn't have on the new contract, on the new
9 network, we've offered them an opportunity to sign
10 over their agreement into our new network.
11 So, if you have historically
12 been with Passport and we didn't contract with you
13 directly, we offered up to each of the providers to
14 join through the decided process.
15 Our strong preference is to
16 contract with each individual provider on our new
17 paper, on our new contract in our new network.
18 Having said that, we have taken
19 the steps to secure the entirety of the network to
20 make sure that there's no access-to-care gaps for our
21 members and for our patients, right?
22 So, again, this is another
23 scenario where it should be a seamless transaction
24 and experience from December to January for our
25 members and for our providers insomuch as access to

1 care is concerned. And hopefully all of the rest is
2 just happening behind the scenes; and just to give
3 you a little inside baseball, that's what is
4 happening behind the scenes. Thanks, Melanie.
5 MS. CLAYPOOL: Thank you so
6 much. The points that Ryan mentioned are already the
7 bullet points here on this slide, but I want to make
8 sure that we also emphasize that if you are already
9 credentialed by Passport, that that's going to be
10 honored by Molina as well.
11 So, there's no need to do any
12 kind of recredentialing. Unless that you're scheduled
13 for any kind of recredentialing, there's no need to
14 credential again for the new network. So, I'm hoping
15 that everybody will be happy to hear that as well.
16 If you are unsure about your
17 participation status or if you want to join the new
18 network and haven't already, the link right here for
19 inquiries is on the slide and you can certainly use
20 that email box to check on that participation status
21 or find out the steps to take to become part of the
22 network. Thank you.
23 I'm going to turn it over now
24 to Dr. Steve Houghland, our Chief medical Officer.
25 Thank you.

1 DR. HOUGHLAND: Thank you.
2 Melanie, a great introduction to this work. We're
3 really concerned about making sure that our members
4 are able to continue and want to work with you
5 through that process.
6 I'm actually going to let Dr.
7 McKune - many of you know Dr. McKune through the
8 years that we've been working together - talk a
9 little bit about the next few pieces here, but if I
10 could just pause.
11 If there's ever any question,
12 concerns that you have, please reach out to me.
13 That's what I am supposed to be doing is helping
14 address any questions that come out. We are here to
15 serve our members and our providers. So, I take that
16 extremely seriously.
17 I know in my conversation with
18 Ryan, he completely agrees; but if you ever have any
19 questions, please, just give me a call, send me a
20 text, send me an email and we'll address it.
21 The next couple of slides are
22 going to talk about our organizational structure and
23 also about our thoughts about the new world of
24 integrated care which we're really excited about.
25 And, Sheila, I know we've

1 talked about this some over the years as well, and I
2 think you know that Liz is going to be really excited
3 about this. I don't want to steal all the thunder.
4 I'll let her jump into some of these things, but this
5 is a new world for us and we're really excited about
6 it. So, Liz.
7 DR. McKUNE: Thanks, Dr.
8 Houghland. It's so good to be with all of you today
9 even if just virtually. I hope you're staying safe
10 and healthy.
11 What I wanted to start with was
12 to briefly go over our organizational structure from
13 a clinical standpoint. And I'm very excited to talk
14 about the fact that we will have a fully integrated
15 community-based team that will be out in the
16 community working with members, as well as our
17 providers.
18 You can see some of the new
19 roles that we have listed here that will be part of
20 those teams, as well as some of the traditional roles
21 that you all are already familiar with, some of our
22 case management roles.
23 We also will be adding
24 individuals that will be experts in navigating
25 substance use disorder and navigating housing

1 challenges. We'll have housing specialists to help
2 connect individuals to opportunities for housing in
3 the community. We will also have some care-
4 connecting nurse practitioners that will be deployed
5 into the community to help us close some of those
6 care gaps.
7 But the second piece there that
8 I really want to emphasize and highlight is that this
9 fully integrated model will have the behavioral
10 health services administered directly by the Plan.
11 We will not be using a subcontractor to assist us
12 with this service. So, we're extremely excited about
13 this piece.
14 If you will go to the next
15 slide. This next slide here shows just an overview
16 of what our Integrated Care Model looks like. You
17 can see that at the very center of this is the
18 enrollee, and the rest of it is designed to look at
19 how we can create that comprehensive circle of
20 support around the individual.
21 So, you've got that first solid
22 blue line there. That's the care manager that's
23 going to be the point person. That is the single
24 point of contact to bringing in the other resources
25 necessary that we have on the internal side, as well

1 as connecting to those all-important community
2 resources on the external side.
3 Across the bottom, we have
4 (inaudible) dimensions to help support recovery. And
5 as you can see, it not only includes the help that we
6 always talk about but also those important
7 connections to housing, the community and that sense
8 of purpose.
9 So, go ahead to the next slide,
10 please. On this slide, we talk some about quality.
11 Quality is at the root of everything we do. The
12 QAPI, the Quality Assurance and Performance
13 Improvement Plan, is the plan that's kind of like our
14 strategic plan for how we are going to address health
15 issues within the Health Plan annually.
16 We continually hold ourselves
17 accountable to this plan. This plan will definitely
18 include the things that we've been talking about
19 today, so, things related to the opioid crisis,
20 things related to low-birth-weight babies, all those
21 important health goals that we collectively with
22 providers and with the members themselves are moving
23 toward so that we can improve the overall health of
24 the Commonwealth because that's part of what we're
25 charged with in being one of the partners with the

1 Department for Medicaid Services to address these
2 health needs.
3 We have a community-based
4 regional approach in that we will have regional QAP
5 committees, so, those committees that look at quality
6 and help us stay accountable to the plans that we
7 have in place so that we can have that direct
8 feedback out around the Commonwealth and ensure that
9 we're all working in tandem toward achieving those
10 health goals; and, then, lastly, by driving quality
11 by partnering with providers.
12 Next slide, please. Along with
13 this, as we've talked about today, we've had an
14 emphasis on telemedicine. We hope to build on the
15 tremendous growth that has happened during this
16 pandemic. I guess as we frequently say in my work
17 when I work with individuals as a behavioral health
18 professional that in crisis comes opportunity.
19 And one of those opportunities
20 that's come in the pandemic crisis has been that
21 increased access to telehealth services for our
22 enrollees.
23 So, along with this, we will
24 work to create or have available our telehealth
25 resource guide online that will hopefully address

1 some of the barriers or challenges if a provider
2 would need some assistance in order to deliver those
3 services and has an area that we can assist with.
4 Additionally, we will have that
5 24/7 access to a physician or a nurse practitioner
6 for urgent medical care needs. At the close of that
7 visit, we will direct any information from that back
8 through the case manager to the primary care
9 provider.
10 And we'll be doing ongoing
11 external communications to keep providers in the loop
12 as well as our members in terms of opportunities to
13 continue to utilize those telehealth visits as we all
14 navigate this together through the end of the
15 pandemic and end of the emergency orders.
16 Next slide, please. This slide
17 here briefly speaks about our value-based program
18 strategy. We understand that in order to move the
19 needle on health, providers are going to be where
20 that action happens.
21 And, so, we are going to be
22 working with providers to put value-based contracting
23 in place to address the important pieces of keeping
24 the focus on quality versus the individual widgets.
25 We do this by aligning our

1 goals and our incentives across the health care
2 continuum, as well as having access to technology.
3 We will have our provider portals available in which
4 providers will have access to information realtime
5 that impacts the individual sitting in front of them,
6 as well as the population of Passport by Molina
7 members that the provider is working with.
8 We will be transparent during
9 this process and provide information as it becomes
10 available so that you can be well-informed as to your
11 planning for work with enrollees.
12 We also will balance that
13 quality as well as efficiency without compromising
14 care and, then, work toward driving continuous
15 improvement together.
16 Next slide, please. So, next
17 I'd like to hand it back over to Dr. Houghland to
18 talk with you some about our prior authorization
19 process.
20 DR. HOUGHLAND: So, super
21 excited now. Thank you, Dr. McKune. You did a great
22 job and I know that you're a little under the
23 weather. I hope you're doing well. I really
24 appreciate that, and as always, you did a great job.
25 So, prior authorization I know

1 is not the most exciting thing in the world. We've
2 outlined some of the tenants that we're looking at.
3 I think, for me, the important things to point out
4 for you is that there's not a big change. It's still
5 focusing on what makes the most sense for our
6 members. These will be published; and if there's
7 ever any questions, please let us know.
8 I'm not going to go through
9 each one of these bullet points, but I think if you
10 do dive into those, you'll see that there's not a big
11 change between what we have been doing historically
12 and what we will be doing in the future.
13 We will rely on international
14 and national criteria for this work. And, again, if
15 there's ever any questions, please just give me a
16 call. I have one cell phone. I'm pretty available.
17 If there's ever any questions, please let us know.
18 That's why we're here and serving our members is so
19 important.
20 So, I think, Sharley, the next
21 three slides probably are related to PA information.
22 If there's any questions for the group, please let me
23 know, but being thoughtful about the time for this
24 group and allowing questions at the end, maybe we can
25 just move on to Slide 22 and value-added services.

1 MS. HUGHES: Steve, I will send
2 this out to all the MAC members and we'll post it on
3 the MAC website. So, they'll have that information
4 for the prior authorizations as well.
5 DR. HOUGHLAND: I really
6 appreciate it. Thank you, Sharley.
7 MS. CLAYPOOL: Thank you so
8 much, Dr. McKune and Dr. Houghland - a wonderful job.
9 Let's move on to some of the
10 extremely wonderful value-adds that we do have for
11 our members. The list that you see here is not all-
12 inclusive but some highlights of the wonderful things
13 that are provided for the members.
14 We're excited to report that
15 these include gift cards that range from $10 to $50.
16 There's $100 toward glasses or contacts for every
17 twenty-four months, free glasses for kids and teens
18 that are under twenty-one.
19 Our pharmacy, CVS, they get a
20 20% discount card and free over-the-counter drugs;
21 free cell phones that have text and email alert
22 programs. There's free community assistance
23 programs, GED prep and testing. The list goes on and
24 on - 24-hour help lines, and, of course, our 22 years
25 of experience in the Commonwealth.

1 So, I think all of you know
2 just the rich group of benefits that we do work with
3 our providers for our members. The 2020 version is
4 under review but that will be coming out soon as
5 well.
6 You can go to the next slide.
7 Thank you. At Passport, we say that there is no
8 wrong door to come in, never a wrong door. And, so,
9 we have many, many ways that our members and our
10 providers can reach us.
11 You've heard Dr. Houghland
12 offer his personal cell phone several times this
13 morning. So, we want to be in touch with you. We
14 offer many, many ways and you can see these numbers
15 listed here.
16 One of the things I think
17 you'll also be grateful to hear is that these numbers
18 didn't change. So many times when there's a
19 transition, we've got to get used to new phone
20 numbers and fax numbers and that kind of thing, but
21 all these numbers are the same and, so, that helps
22 everybody with this transition.
23 You can go to the next slide,
24 please. So, in closing, I want to reiterate that
25 Passport by Molina Health has made significant

1 commitments to our Commonwealth, including more great
2 jobs for Kentuckians. We are hiring locally across
3 the entire Commonwealth. We continue our
4 headquarters in Louisville, but the new six One-Stop
5 Help Centers are going to be fabulous a round the
6 state.
7 There's been a $2.5 million
8 investment in community organizations already with
9 many innovations to also address our social
10 determinants of health which is so important for our
11 membership.
12 We are ready for a successful
13 transition to 2021 and beyond. And with that, I will
14 close and see if we have questions.
15 DR. PARTIN: Does anybody have
16 any questions?
17 MS. EISNER: This is Nina. Just
18 a simple one. Can you all share your slides? I know
19 we saw them on the screen but could we also get a
20 copy of them?
21 MS. HUGHES: Yes. I'll be
22 sending a copy right after this meeting, Nina.
23 MS. EISNER: Thanks, Sharley.
24 DR. PARTIN: Thank you very
25 much. That was very informative and we look forward

1 to working with Passport by Molina.
2 So, next up on our agenda is
3 election of officers.
4 DR. CANTOR: Dr. Partin, can I
5 enter just a quick second? My name is Dr. Cantor.
6 Thank you. Appreciate that. I'm with United
7 Healthcare Community Plan; and as you noted, we are
8 in readiness review.
9 So, we don't have a report, but
10 I just wanted to put a shout out for the low-birth-
11 weight topic that was brought up. That's quite near
12 and dear to me as an OB/GYN and having practiced
13 many, many, many years here in Louisville, Kentucky.
14 I know from United HealthCare's
15 perspective, we would be happy to be strategic
16 partners with that and I just wanted to put that out
17 there. Thank you so much.
18 DR. PARTIN: Thank you. We look
19 forward to hearing any recommendations that you have.
20 So, Sharley has put together
21 the election. I'm not sure how----
22 MS. HUGHES: Well, it's actually
23 going to be pretty easy, Beth. The only person that
24 requested to be Chair was you. The only person
25 requested to be Vice-Chair is Dr. Bobrowski. And

1 Teresa was the only one mentioned being for
2 Secretary. So, unless someone else comes up, you all
3 will be it.
4 MS. EISNER: Do we need a motion
5 to approve the slate as presented?
6 MS. HUGHES: Yes. I think you
7 would do that and, then, just everybody vote to make
8 it official.
9 MS. EISNER: I'd make that
10 motion.
11 DR. HANNA: I'll second.
12 DR. PARTIN: Any discussion?
13 All in favor, say aye. Anybody opposed? Thank you
14 very much and thank you for the confidence that
15 you've placed in me and the other officers. We
16 appreciate it.
17 Our meeting dates for next year
18 will be the fourth Thursday of the month and they
19 will be quarterly meetings except for November which
20 will be the third Thursday because of Thanksgiving.
21 Sharley, can you send us the
22 specific dates?
23 MS. HUGHES: I can give you
24 those dates now if you'd like.
25 DR. PARTIN: Okay.

1 MS. HUGHES: And I'll send them
2 out also, but just so it's on the record, it's
3 January 28th, March 25th, May 27th, July 22nd, September
4 23rd, and November 18th.
5 DR. PARTIN: Thank you. And,
6 also, Sharley, could you send members of the MAC a
7 list of members and their contact information?
8 MS. HUGHES: Yes, ma'am.
9 DR. PARTIN: Thank you. That's
10 all we have for our meeting this time. And since it
11 was a special-called meeting, we can't add anything,
12 but our next meeting, we will be able to add to that
13 if anybody has new items that they want to bring up
14 at the meeting.
15 So, I would like to wish
16 everybody happy and safe holidays and I look forward
17 to seeing everybody back in January. Thank you. A
18 motion to adjourn?
19 DR. HANNA: Motion to adjourn.
20 DR. COMPTON: Second.
21 DR. PARTIN: All in favor.
22 Thank you, everyone.
23 MEETING ADJOURNED
24
25