COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

IN RE: CONSUMER RIGHTS AND CLIENT NEEDS
TECHNICAL ADVISORY COUNCIL

February 15, 2022
1:30 P.M.
All Participants Appeared Via Zoom or Telephonically

APPEARANCES

Emily Beauregard
CHAIR

Miranda Brown
Arthur Campbell
Christine Jackson
Rose-Linda Stafford
TAC MEMBERS PRESENT

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DEPARTMENT FOR MEDICAID SERVICES

(Court Reporter’s Note: At the request of DMS, all other participants appearing via Zoom or telephonically will not be listed under Appearances.)
AGENDA

1. Welcome & Introductions

2. Approval of December, 2021 minutes

3. Old Business
   a. What more has been done to address issues kynectors have reported since our December meeting?
   b. What updates are there on the development and dissemination of a document explaining the difference between Presumptive Eligibility and Emergency Time-Limited Medicaid?
   c. What is the status of the diagram DMS is drafting for Medicaid/KCHIP eligibility?
   d. What is the status of adding monthly Medicaid/KCHIP enrollment reports to the statistics’ page?
   e. What is the status of amending the State Plan to lift the 5-year bar on covering legally-residing pregnant women?
   f. What is DMS doing to ensure network adequacy requirements are met? What can an enrollee do if their MCO is not meeting those standards? It would be helpful to have a one-pager/decision tree that breaks down the steps to take with an MCO vs with DMS.
   g. What is the status of the Health Disparity and Equity TAC?

4. Medicaid Enrollment & Recertification
   a. How many Kentuckians are currently covered under traditional/expanded Medicaid? How many are currently covered under Presumptive Eligibility (PE)?
   b. How many Kentuckians were covered under PE Medicaid in February 2020? And/or on average per month in 2019?
   c. How many current PE enrollments resulted from applications that were submitted via 1) the public-facing portal; 2) providers; and 3) DCBS?
   d. What is the timeline/process for incorporating Emergency Time Limited Medicaid pre-application/pre-approval into Kynect?
AGENDA
(Continued)

e. How can MCOs, providers, and community partners work with DMS to educate Kentuckians about the MOE and the redetermination process/timeline?

5. 1915(c) Waivers
   a. Transportation is a major barrier for many waiver recipients. What options are or could become available through each waiver program for transportation assistance?
   b. What is the status of final approval for the full HCBS spending plan? What is the timeline for implementation?
   c. What feedback has DMS received from meetings with consumers/providers related to the enhanced HCBS FMAP?

6. New Business
   a. How can/will Medicaid enrollees be able to access free over-the-counter COVID tests?

7. Recommendations for the March MAC Meeting

8. 2022 Meeting Schedule
   a. Upcoming TAC meetings: April 19, June 21, August 16, October 18, December 20 at 1:30pm ET
   b. 2022 MAC meeting dates: March 24, May 26, July 28, September 22 and November 17

9. Adjournment
MS. BEAUREGARD: We will go ahead and get started. I know that there are a lot of meetings going on today and DMS staff are kind of stretched thin.

We have a quorum and we can go ahead and get started and, then, Patty, when she is able to join us.

So, I’m Emily Beauregard for anyone who doesn’t know me. I’m the Consumer TAC Chair and also the Director of Kentucky Voices for Health.

So, welcome to our Consumer TAC meeting and thank you all for joining us today. We’ll go around and quickly introduce our TAC members. At this point, if everyone can make sure to have your video on, that would be helpful. We need that for a quorum.

(INTRODUCTIONS)

MS. BEAUREGARD: The next item on the agenda is approval of November minutes and I think that I may have gotten that wrong. We don’t have November minutes. We have December minutes. Am I right?

MS. BROWN: Yes, you’re right.

MS. BEAUREGARD: Sorry about
that, everyone, but if I could get a motion to
approve the December minutes and, then, a second.

    MS. BROWN: I motion to approve
the December minutes.

    MS. JACKSON: I’ll second it.

    MS. BEAUREGARD: Thank you,
Christine. All in favor, say aye. Any opposed?
Motion carries. Thank you.

And, then, we will start with
- well, actually before we just go through the
agenda as the order that we have it here, are there
any folks from Medicaid here who need us to go in a
different order?

    So, we can change things as we
go but we’ll start right now with Old Business and
that first item which is the issues that have been
reported by Kynectors and anything that has been
done since our last meeting which was in December to
address some of those issues.

    MS. GUICE: This is Lee Guice.
I think that we addressed those issues as we stepped
through them, and I’m hoping that any actual bugs
were fixed as we went through. So, I haven’t heard
anything for a little while. So, I hope that
everything was actually taken care of.
MS. BEAUREGARD: I know that many of the issues that were reported to the KHBE and Deloitte were addressed if they were system errors, but there were those issues with name changes and a few other things that I think Miranda may have reported, especially related to some of the cases for immigrants that she has been supporting. Miranda, have those things been resolved?

MS. BROWN: I’m not sure about name changes. That’s not an issue that I have seen specifically.

MS. BEAUREGARD: Those were ones that Priscilla and Kara and a few other Kynectors have reported.

MS. BROWN: An issue that I have continued to see is sometimes - last week this didn’t happen on a case but it has happened recently - which was Emergency Medicaid cases will not show results at the end. It will say your case is pending a 30-day review; and if we call DCBS, they say they don’t see an application. So, it doesn’t appear to have processed.

MS. GUICE: That’s news to me. So, I don’t know. Have you sent - did you tell DCBS when you called them----
MS. BROWN: Yes.

MS. GUICE: ----that it doesn’t appear to have processed?

MS. BROWN: Yes.

MS. GUICE: Did they say anything about reporting it to the Help Desk?

MS. BROWN: I’d have to pull up my notes to see exactly what was said.

MS. GUICE: Because that would certainly be a technical issue.

MS. BROWN: Right. Usually they just say, well, just resubmit the application and I’m like, well, what if the same thing happens? And sometimes they have done it over the phone with us at that point, but it is an issue that if the system says it is processing a case, that it’s actually not processing at all.

MS. GUICE: Well, yes, it is a technical issue and working around it with DCBS. I guess we need to remind them that using a work-around, yes, it’s good to get coverage, but we also need to have that information sent forward so that we can research and try to find what the issue is.

The next time it happens,
Miranda, if you could take a screen shot and send it to me, that would be great.

MS. BROWN: Okay. Thank you, Lee.

MS. GUICE: Sure.

MS. BEAUREGARD: Lee, I know that Kara and Priscilla have sent you some issues with the name changes.

MS. GUICE: Right.

MS. BEAUREGARD: They were being overwritten. Like, somebody would update their information and, then, it would go back to the old spelling or an old name. Is that something you’ve been able to look into?

MS. GUICE: We send those - let me explain how that works, okay, and why it works the way it does.

In order to make sure that we have one person, with one Lee Guice in the system, whether or not I spell my name Lee A. Guice or just Lee Guice or somebody misspelled it with an “s” instead of a “c”, we have what’s called the Master Client Index.

And when there has been an issue or when somebody has reported a change to
their name and it hasn’t been verified, like, we have a Social Security card on file that has my name as Lee Ann Guice and I call DCBS or I ask for my name to be changed to Lee Guice but I don’t ever send anything, the Master Client Index is not going to allow that change to be made.

MS. BEAUREGARD: Right, right unless you have updated verification, right?

MS. GUICE: Right, unless you’ve updated the verification.

MS. BEAUREGARD: I think these are cases in which updated verification was provided.

MS. GUICE: Well, then, it shouldn’t have happened.

MS. BEAUREGARD: I agree with you.

MS. GUICE: I’ll tell you. When they send me information like that, I send it forward to the Help Desk to see if they can determine what has caused something to be overwritten because it shouldn’t be overwritten unless the circumstances I described have occurred.

So, I’m hoping that all of those have been addressed unless I have some of
those emails still sitting in my inbox waiting for me to get to them.

MS. BEAUREGARD: I’ll check with Priscilla and Kara and see if they can just re-send it to you or look at the status. They can probably look up those clients in the system to see if something has changed.

MS. GUICE: Okay. Great.

MS. BEAUREGARD: These were unusual cases, not the typical.

The next item or question, what updated are there on the development and the dissemination of a document explaining the difference between Presumptive Eligibility and Emergency Time-Limited Medicaid?

MS. GUICE: It’s still under review.

MS. BEAUREGARD: Okay. Do you have an idea of when it will be available for us to take a look at?

MS. GUICE: I do not. Probably two days after a couple of other people are cloned in Medicaid. I’m sorry. I don’t know right now.

MS. BEAUREGARD: Yeah, I know. I know things have been very busy. Okay. Well, any
updates you can share would be great. And if it’s possible for us to review a draft just to get some feedback to you, we can keep it confidential amongst just the members of the TAC.

The next question here is the status of a diagram that I think you have been drafting, Lee, related to Medicaid and KCHIP eligibility.

MS. GUICE: Yes, and I do have something, to give you a deadline sort of. We were working on the sample that you gave us which was fine until I was given another task to redo a chart from another state to put in our annual report and that is a much, much better, in fact, chart, and I have wisely delegated that responsibility to someone else and given them a deadline.

So, we should have that to review by early next week. I should get it by the end of this week and, then, I’ll do just a cursory review and let a couple of people inside the Cabinet take a look at it and, then, we’ll send it to you all to see if it meets your standards.

MS. BEAUREGARD: Yeah. That sounds great. Thank you.

And, then, the Medicaid/KCHIP
enrollment reports that are going to be on the statistics’ page, I actually didn’t check before this meeting if that had already been added.

MS. GUICE: I’ve asked for it to be added. I have not checked to see if they’ve been added but I have asked for them to be.

MS. BEAUREGARD: Okay, and they’ll be updated monthly now?

MS. GUICE: Yes.


The next question is the status of amending the State Plan to lift the five-year bar on covering legally residing pregnant women.

MS. GUICE: You know, what I don’t know is has that decision been made by leadership is what I’m unaware of.

And, so, Veronica was in a meeting and couldn’t be here for a little while. If she gets on the - if she’s able to join the call, can you just go back to that?

MS. BEAUREGARD: Yeah, we can do that.

The next one is what DMS is
doing to ensure network adequacy. This was
something else that may be a Veronica question - I’m
not sure - to ensure that these network adequacy
requirements are being met, and more specifically
what an enrollee can do if their MCO is not meeting
those standards.

MS. PARKER: This is Angie
Parker with Medicaid. I can answer and I will start
with the first question. What is DMS doing to
ensure network adequacy requirements are met?

Each MCO submits a report on a
quarterly basis and it is reviewed by DMS personnel.
As we know, there are challenges sometimes with
certain areas for MCOs to acquire contracts and even
if they have the contracts with those Medicaid
providers to see Medicaid enrolles.

So, those do occur from time
to time. We also review complaints that comes to our
attention.

And what can an enrollee do if
their MCO is not meeting those standards? If an
enrollee has a specific physician they need to see,
there are 30-minute/30-mile rules for your primary
care and hospitals and there are 50-minute/50-mile
rules for other specialists.
So, if MCO A, the enrollee wants to see Dr. Smith, and MCO A in which the enrollee is enrolled does not have MCO A but they do have a provider, Dr. Jones, who does the same type of services within their network within the same period of time or miles, they may request that they see that provider who is in their network.

Obviously, if they supply the same services, then, it’s a possibility they may ask the enrollee to go to a different provider.

If they do not have that provider in their network or within a reasonable time or miles, the MCO is to work with that enrollee to find the services in which they need or require.

If it comes down to they want to switch because they don’t want to see Dr. Jones or Dr. Smith, then, they can apply for a disenrollment for cause with the MCO and the MCO will either, one, work with that member and/or try to get a contract with that provider in order to provide the services in which an enrollee needs.

I can’t give you it’s X or Y because there’s a lot of different variables that could come into play here in which network adequacy is evaluated for the particular enrollee.
MS. BEAUREGARD: I know it’s somewhat complicated. What I hear is that when someone calls in to the Member Services’ line for an MCO, they can be given – there’s a provider directory, of course, and they can be directed to any of the providers that would be within those distance standards.

Now, the time standards are obviously not as clear because you don’t get that information unless you make the call.

And, so, then, the enrollee can be kind of tasked with having to make calls to ten or more providers to see if they have an appointment available.

And, then, that often results in being told that they are not taking new patients or that they’re not even participating with that MCO or they may or may not have an appointment available within those time standards.

But I don’t know that the enrollee is being told on the phone make these calls. If there is no provider available within this time frame, call back and we will approve someone out of network.

It seems like that’s the piece
that’s kind of - that’s where the breakdown is and it puts all the onus on the enrollee to do all of this legwork to determine if there’s a provider that is available within a reasonable amount of time.

MS. PARKER: Well, I mean, as you said, there is a provider network that does address certain specialties, but I would suggest if they’re having issues with the Member Services at the MCO that they say, well, I have contacted X, Y and Z and I have not been able to, they should be able to provide assistance in determining who they can see.

MS. BEAUREGARD: Are the MCOs required to tell someone up front if you cannot find a provider within these time standards or these distance standards, we will, then, approve someone out of network?

MS. PARKER: Are they required to tell them?

MS. BEAUREGARD: Yes, that’s my question.

MS. PARKER: They have to find services for the enrollee. So, if it’s something that they need, if it’s primary care or if it’s a gall bladder surgeon or a surgeon, a general -17-
surgeon, they should be able to assist that member if they’re having challenges in locating that particular provider.

MS. BEAUREGARD: Yes. I guess I feel, from what I’ve heard, that they’re not necessarily up front with what they are required to do and what the enrollee needs to do in order to get an out-of-network provider at the end of the day.

It can be one of those things where it’s a lot of back and forth and a lot of work being done on the enrollee’s part to find a provider.

I think it would be helpful if up front the person on the call said this is what we’re required to provide. If you can’t find a provider that meets those standards, then, we will.

I think getting somebody that information up front would be helpful because not everyone knows the rules. I would guess that the majority of people don’t know.

MS. PARKER: Well, I mean, an MCO can only make really recommendations. So, they have a provider network and they have all these providers in this area and that Member Services will say, well, we have Doctors XYZ and ABC in your area.
And, yes, they cannot specifically recommend somebody because they all are the same specialties, they’re all primary care. So, it is an individual choice of those network providers who that member wants to see or can see.

So, like I was kind of explaining earlier, there is all these providers. There’s A&B, Doctors A&B in this area but the enrollee prefers A. Even though they provide the same type of service but that A is not in their network, they could still go to B who is in their network.

MS. BEAUREGARD: Right. Right No, I understand the issue of preference and that’s not really what I’m talking about right now, just access to a particular type of service that meets those standards.

But I guess maybe this could be a recommendation that we make, that the MCOs be required to disclose up front that if there is not a provider available within the time or distance standards, that the enrollee can then call back and get an out-of-network provider approved.

I feel like that’s the only way that people will know that that’s a process that
they can go through and something that they can request because most of the time, if you’re told no, you just assume that something is not available and you kind of give up.

MS. PARKER: I would always love to hear when those challenges are happening.

MS. BEAUREGARD: Well, we know they’re happening because the Secret Shopper surveys that are being done are finding that more times than not, whenever a provider is called who is a Medicaid participating provider, they’re not available within those time standards.

So, we know that they’re happening.

MS. PARKER: Right. I don’t want to debate that with you because I know we’ve both talked about that before and I understand where you’re coming from on that and it’s twofold, as we’ve talked about.

They may be contracted with the MCO and they have openings but they allow other insurers first and a lot of that is in what a provider chooses to do. Is that right? No, it’s not. And if that is occurring, that would be something that the MCOs or DMS would have to handle.
or address.

But to your point that people give up because they can’t get in, then, yes, the MCO should be assisting with access to care.

Now, there is disenrollment for cause which I’ve talked about and there is information on the website on that and it’s also addressed in the Member Handbook. And a lot of that information on access to care and the Member Services’ information should all be in the Member Handbook.

MS. BEAUREGARD: Yes. There is information and it is different from one handbook to the next.

And one thing that we had actually recommended on our last Consumer TAC meeting, the recommendation that we made to the MAC and I believe the MAC - oh, they did not have a quorum, so, it may not have come through yet - but was to create a one-pager that could explain more consistently what those steps would be for an enrollee to go through; and if something is not available, what they can do to either get the out-of-network provider approved, or, if that’s not happening, if the MCO is not agreeing to it for
whatever reason, what they can do to submit a
complaint.

So, I think that process just
needs to be more clearly sort of defined for
enrollees and that’s a recommendation that we’ve
already made.

MS. PARKER: Okay.

MS. BEAUREGARD: One other
thing I wanted to clarify with you, you had said
that you also review complaints when they come to
your attention.

How do those complaints come
to your attention? Like, what kind of - are they
from the enrollee and how would they be able to
submit that?

MS. PARKER: Well, enrollees,
there is a website - not a website - a web address.
I believe it’s dmsshare but I will have to get that
specific to make sure that you have that in the
minutes - that we get them from there but they go to
Sharley and she reviews them and she will send them
to us if there’s an MCO complaint.

It could come from
constituents. It can come from our Member Services’
line in order to address those types of complaints.
MCOs are to keep track of grievances and appeals and when they get those grievances or (inaudible) reporting which they submit to us on a monthly basis. And that is also something, that they are to resolve a grievance within thirty days.

MS. BEAUREGARD: So, all grievances and appeals get submitted to DMS for your review as well. Is that right?

MS. PARKER: The MCOs report them to us when they have grievances, the number of grievances.

MS. BEAUREGARD: Just the number but not----

MS. PARKER: And the type of grievance.

MS. BEAUREGARD: Okay.

MS. BROWN: Angie, I may have missed it, but did you say the time frame in which somebody is supposed to be able to get a primary care provider was in so many days or weeks and specialist appointments, like, how long the provider has to provide an appointment before the MCO should help find a different provider?

MS. PARKER: Yes. There are specific time frames. I don’t want to misspeak but I
believe, if it’s not emergent, it’s just your annual exam, it’s thirty days to see a doctor. If it’s emergent or if it’s urgent, within forty-eight hours. It could be twenty-four. I have it here and I can find that specific information for you.

MS. BEAUREGARD: I was going to say I can pull it up, too, because I put it in some notes a few months ago.

MS. BROWN: Is there somewhere that I can find that?

MS. BEAUREGARD: That’s where I find it very difficult to get that information and for it to be presented in a consistent manner from one MCO to the next.

It’s in regulation and I do believe it’s in the handbooks but the amount of details and, then, what process you can follow in order to get an out-of-network provider approved, I think that’s where it kind of varies significantly and people don’t have that much information.

I’m sorry. Were you saying something else, Angie?

MS. PARKER: No. I’m trying to find the specific language regarding when to see a doctor. I just saw it not too long ago.
MS. BEAUREGARD: I’m trying to pull up the notes and it’s taking me a minute. So, the time and distance standards right now are for primary care, within thirty miles or thirty minutes from an enrollee’s residence in an urban area, forty-five miles or forty-five minutes in a non-urban area, and then, they all put standards in terms of how many days and - let me see - appointment availability.

MS. PARKER: Within thirty days for routine care or forty-eight hours for urgent care. Emergent and behavioral health, within twenty-four hours a day, seven days a week. Urgent care by any provider in the network should be available and accessible within forty-eight hours of request. Immediate treatment for emergency medical or behavioral health by a health provider is based on the type of injury, illness or condition regardless of whether the facility is in the network or not.

So, as I was saying early, it’s within twenty-four hours for an emergency, forty-eight hours for urgent care and thirty days for a routine.

MS. BROWN: Thank you.
MS. BEAUREGARD: Angie, I appreciate this information. If we do get any specific reports that we can share with you, we will; but I think generally having something simple that we can share with enrollees would be really helpful, and just knowing that if we’re seeing this chronically where, with the Secret Shopper surveys, providers are not meeting those standards, I think we need to see not just a case-by-case basis sort of addressing it but more providers that are being contracted.

And we know that there are lots of challenges with that but one certainly is probably what the payment rates are or other sort of more administrative issues that providers experience in working with the MCOs and that really is the responsibility of MCOs ultimately.

So, the case-by-case basis is one way to work on these issues, but if it is a chronic problem and we see that trend continuing, I think that there’s more to be done on the contracting side of things.

MS. PARKER: Well, I would say if you hear of specific MCO complaints on what you all are doing, then, please bring it to my
If you just hear anecdotal information, it’s kind of challenging to address those, but I agree when you’re talking about the Secret Shopper but they’re also to address those when we get those reports and to evaluate that with the provider.

MS. BEAUREGARD: The request that we made or the recommendation that we made at our last meeting, if that’s something that we could work with you on to do that one-pager, that would be fantastic. So, we can follow up with that separately.

And, then, our last question here is the status of the Health Disparity and Equity TAC.

MS. GUICE: That’s a Veronica question, Angie, unless you have something to add on that one.

MS. PARKER: I just know that they’re waiting on a one more application and then they plan on sending it to the Governor once they get that.

MS. GUICE: Okay. Thank you. I did hear something about that. I just forgot what
the response was. Thank you, Angie.

MS. BEAUREGARD: Thanks for that update.

Anything else before we move on to the next section - Medicaid Enrollment and Recertification?

So, our first question here is how many Kentuckians are currently covered under the traditional and expanded Medicaid and how many are covered under Presumptive Eligibility?

MS. GUICE: So, we have 1.66 million total members, 1,600 members in PE.

Your other questions in (b) and (c), I have made data requests to see if I can - I mean, not to see if I can - on (b), to get that information, and on (c), to see if we can get that information.

I don’t know. That would be one of the challenges of getting the agenda late is that we really don’t even have a prayer of being prepared.

On (d) as far as the time line for incorporating Emergency Time-Limited Medicaid is Kynect has been designed and is ready to go but not until we are able to unwind. We made the
determination that we are keeping everyone eligible right now.

So, I know it might be a little bit easier, and if you have somebody that you are having trouble getting Emergency Medicaid approved for, just let me know and we will work to make that happen.

But right now, technically, it would be almost impossible to change our eligibility over completely for one category of member when we have so many fixes in to maintain the maintenance-of-effort requirement.

MS. BEAUREGARD: You’re seeing this as an eligibility change or just a big-system change? Did I hear you wrong?

MS. GUICE: It is an eligibility change. It’s an eligibility system change.

MS. BEAUREGARD: Okay. The eligibility criteria remains the same but it’s part of the eligibility system. Is that what I’m understanding?

MS. GUICE: No. No. No. Sorry. I mean, that might be what you’re understanding, Emily, but that’s not what I meant. I thought, no,
that’s not the right answer, Lee.

What I’m trying to say is CMS - and I know that we’ve talked about this before - CMS contacted us and let us know that we have implemented Emergency Time-Limited Medicaid incorrectly.

And, so, we are going to be correcting that implementation and that’s what I’m talking about.

MS. BEAUREGARD: Okay. I understood that part. When you said eligibility, it meant something different to me.

MS. GUICE: When it says application and approval in Kynect, that means eligibility to me. So, that’s what I was talking about.

MS. BEAUREGARD: Okay. I think for us, we’re looking at people being able to apply through Kynect in advance of having an emergency and be approved only in the case that they would then in the future have an emergency that would sort of trigger the coverage to start.

MS. GUICE: Correct. Right. So, what CMS explained to us is that we are supposed to allow everyone who is technologically and financially
eligible for Medicaid except for their immigration status to apply without having an emergency medical situation but we only pay for that emergency medical situation. So, that is a big-systems change in our eligibility engine.

MS. BEAUREGARD: And, so, you are planning right now to do the unwinding of that maintenance-of-effort which has kept people covered and enrolled in Medicaid during the pandemic first and, then, do the system change for Emergency Medicaid.

MS. GUICE: Pretty much maybe not right together but closely, close in time.

MS. BEAUREGARD: Okay. Thanks. Miranda, do you have any follow-up questions? I know that’s something that you’ve done. Okay.

Then, the last question here is how can MCOs, providers and community partners work with DMS to educate Kentuckians about the MOE unwinding and the redetermination process and time line?

MS. GUICE: We have some facilitation assistance now to put together a communication strategy plan and we’ll be asking for folks from the community as well as our MCO partners.
to come to the table and help create that plan and work with us on it and that is where we are.

I put both yours and Miranda’s name down, but certainly if anybody else on the TAC is interested in joining the meetings, send an email to wherever Erin is taking her emails up through and I will put you on my list.

MS. BEAUREGARD: Okay. Thank you. Are you still anticipating that - like, I think the number that you gave us last time for the number of people who would have to actively recertify would be less than 200,000. Is that still your thinking?

MS. GUICE: No. That 200,000, less than 200,000 will be the number of people that will likely be terminated from Medicaid.

MS. BEAUREGARD: Who would no longer be eligible.

MS. GUICE: Correct.

MS. BEAUREGARD: So, how many do you expect to actively recertify versus passive renewal?

MS. GUICE: Well, we generally have about 75% success with our passive renewal, however,
and I don’t know that breakdown.

The non-MAGI folks have less of a chance of getting into the passive renewal pipeline than the MAGI methodology because some resources change in value as time goes by and they cannot be passively renewed or incomes that go up and down can’t be passively renewed.

So, there are only — and I don’t know what that — I used to know what the percentages would be but I just don’t know right now.

So, if you want to know that, say so in a question and make sure it’s on the agenda and I can find that out for you next time.

MS. BEAUREGARD: And ask for the breakdown between MAGI and non-MAGI?

MS. GUICE: Sure.

MS. BEAUREGARD: Okay. And just for the benefit of our other TAC members, MAGI stands for Modified Adjusted Gross Income which was a change that I believe was part of the Affordable Care Act. Is that right, Lee?

MS. GUICE: Yes.

MS. BEAUREGARD: And, so, it’s a different way of looking at your income and
doesn’t include assets, whereas, non-MAGI includes some assets. Is that right?

    MS. GUICE: At a very high level.

    MS. BEAUREGARD: I’m trying to make it really simple.

    MS. GUICE: The MAGI methodology looks at your taxable income only and non-MAGI is where different kinds of income and certain levels of resources are also part of the calculation. So, that’s what you said.

    MS. BEAUREGARD: And, typically, the majority of Medicaid enrollees are going through the MAGI process now. Is that also correct to say?

    MS. GUICE: Yes. Most of the non-MAGI enrollees will be long-term care supports and services. So, nursing facilities, ICF/IDD’s, the 1915(c)waivers.

    MS. BEAUREGARD: Thank you. It’s just lots of details and nuances in all of these programs. So, I appreciate that.

    Any other questions related to enrollment and recertification that people have?

    MS. JACKSON: Emily, is this a
good time for me to share?

MS. BEAUREGARD: Yes, I think it is.

MS. JACKSON: Okay, because a lot of what you all were saying I’ve dealt with.

So, just so you all know, I actually was on Medicaid before I even was asked to be on this board. So, I’m kind of like a very perfect example of somebody going through a lot of what you all saying from the user end.

So, I had a situation with COVID and a combination of caring for our 90-year-old in-laws, Mom with dementia.

My husband went back in 2020 unemployed and I had a medical condition and with no insurance. So, I found out I could get Medicaid. Got it. Then, last year, my husband became gainfully employed, reported the income and was told that we still qualified which I was surprised but, you know, I’m not going to complain. Sure. That would be good. Because he does contract work, he doesn’t get insurance very easily.

So, I wasn’t sure about that, and, so, I got a Kynector to help because I couldn’t really understand how that worked and she got me on
the phone with, like I said, it would be DMS or DCBS and it was verified with somebody on the other side because she wasn’t sure about it.

And, so, time went on and he jumped a couple of jobs because he does contract work and, then, it turned out he got another income increase. So, we called again and found out that we’re over that, and, so, we had to pick a Qualified Health Plan.

So, I tried to do it on my own and I could not understand it. I have a college degree and I ran a business for sixteen years and I couldn’t figure it out.

So, I called the Kynector back to help me with that. And at the end of last year, we got the notices that our Medicaid was going to run out the end of January but we did still report the increase in income.

So, then we got told that we’d get this tax - what’s it called again - the tax credit - I forgot the name of it - the word for you get a tax allowance.

MS. GUICE: It’s Advanced Premium Tax Credit.

MS. JACKSON: That’s right, and
it showed up and we thought, okay, good. And, then, my husband, I said you better check with your contractor. Can they cover insurance or not because Medicaid is going to run out, and he had one day to figure it out. For him, it was going to be $500. To add me was going to be $1,600 a month.

So, our Kynector asked us to report all of that, the offer and everything; and when we did, the tax credit disappears.

And, so, then, we thought, oh, shoot, because the range, looking at all the health care plans available through the QHP, starts at around six or seven and, then, goes on up, right, depending on your bronze, silver and gold.

So, then, I was like, shoot, you know, it’s still going to cost us a lot of money.

So, then, like, I talked to Emily about it and she had Priscilla, one of the Kynectors in her office, help me a little bit; and during that time, I went back into the website and, then, the tax credit was back there again.

So, I went ahead and signed up for it, but I wanted to sign up for it so that it would become effective February 1st but we had all...
these technical issues going on and I didn’t get to
sign up for it until the end of January.

So, apparently, the coverage
is not effective until March 1st, right, because if
you waited from the 15th to the 30th, but Priscilla
told me and she showed me the document for natural
disaster and technical issues’ special enrollment,
but we couldn’t figure it out how to do it in time.

And, so, she’s supposed to be
checking on it but I still haven’t heard whether it
could be retroactive so that it becomes effective
because there was so much technicality.

So, to summarize it all, it
was very difficult to go through and I still don’t
really know. I believe I have coverage through QHP,
although I haven’t seen any paperwork from anybody
or an email. I think it’s online.

And, then, I don’t even know
do I have insurance coverage right now or not or
through QHP. I know the Medicaid expired in January
because of all those changes that we reported in
income.

MS. GUICE: Christine, a few
minutes ago I talked about the maintenance-of-effort
requirements.

-38-
MS. JACKSON: Yes.

MS. GUICE: And the maintenance-of-effort requirement means this. If you have Medicaid during the emergency, during the public health emergency, we could not terminate you, period.

MS. BEAUREGARD: Lee, that’s what I actually told her when she called me and I said this must be a mistake, but, Christine, you got a letter that said you were terminated.

MS. JACKSON: Yeah. It wasn’t a letter. You know how on the site it will tell you----

MS. GUICE: Yes.

MS. JACKSON: ----something that tells you what’s going on and it did. At first, it said that we weren’t expiring until February, the end of February. So, we kind of didn’t worry about it.

But when I got on with the Kynector and somebody that we called in to, they just took all the information and, then, it came out on paperwork on the website saying that we requested to get out of Medicaid but we did not. We just reported what we were supposed to do. Whenever your

-39-
income changes, you’re supposed to update and
report it and that’s what we did, but the verbiage
made it sound like we asked to get off of it.

MS. GUICE: Well, that’s the
only reason – right – that is the only reason that
we could terminate you is if you moved out of state,
you passed away or you requested it.

Now, if you applied for a QHP
and advanced premium tax credits, you would not be
eligible for that unless you terminated your
Medicaid. You can’t get benefits at the same time.

So, I don’t know why your
Kynector did not understand that. I don’t know why
you got a letter saying that – well, I do know that.

Some people do get a letter
saying that because they had reported their incomes.
And when we switched our system back to the State-
based marketplace, some notices went out indicating
that your Medicaid was going to end at a certain
date and QHP would be – you would be eligible for a
Qualified Health Plan but that’s not true.

We tried to post it and
trained everybody to understand that that was not
true. It was just not true.

I am very sorry. If you want
to privately send me your birth date and the last four of your Social, I’d be happy to look it up for you and see if you’re still eligible for Medicaid. You might not be but you should be if you didn’t ask to be removed.

MS. JACKSON: Okay. Great. I appreciate it. We were just reporting the income change. Who wants to pay hundreds of dollars a month if they don’t have to, especially when you’re digging yourself out of a hole.

So, I’ll do that. So, birth date and did you say Social?

MS. GUICE: The last four of your Social would be helpful so that I can make sure I have the right person.

MS. JACKSON: Great.

MS. BEAUREGARD: Lee, I know the letter that you’re talking about that went out, right, right before open enrollment. That’s not the same as what Christine received, but I appreciate you looking into it for her.

And, of course, we’re concerned that maybe other people have been terminated for reasons that don’t fall into those, that they moved out of state or requested.

-41-
So, I wanted to share this one with you so that if there was a system issue or maybe just a training issue that it could be addressed.

MS. JACKSON: So, that’s the Medicaid side of it. So, once we thought, okay, well, we don’t have Medicaid. Even getting the Qualified Health Plan, we did get a document saying that we had the tax credit and, then, we got a document showing we don’t, and, then, we got a document again saying we do.

So, that whole was kind of stressful and it was stressful enough that I gladly sought the help of a second Kynector and I don’t even know when the Qualified Health Plan goes into effect.

But I appreciate if we can get that all resolved and smoothed over and I guess I’m the little guinea pig here.

MS. GUICE: I am sorry you had all that trouble.

MS. JACKSON: I told Emily, it’s like, wow, I guess I was supposed to be on the board.

MS. GUICE: Perfect timing. It
is complicated but it only should be complicated for us. It should not be complicated for anybody who needs services. So, my deepest apologies for that.

MS. JACKSON: Thank you.

MS. BROWN: I was just going to add. So, it’s kind of like two issues with Christine’s situation it sounds like, two main issues at least, and one of them being that their notice said they requested withdrawal and they didn’t.

And I had a case like that in November and December and that case has since been fixed but it was a long process to get it fixed. And if it would be helpful, I can send you the case number so you could look into the history of it.

And, then, the other situation would be APTC going up and down without the applicant having put in any additional changes. That has happened in several of my cases as well, and I’ve been reporting them through the Issue Tracker as time has gone on but I have wondered as to are these cases being fixed on an individual basis or is the bigger problem, is that also being fixed?

MS. BEAUREGARD: Miranda, I
think sharing those would be helpful because I think you’re right. The Issue Tracker is great to resolve an individual case, but it’s unclear if the system issue is being fixed that way.

MS. GUICE: Generally speaking, if there is a trend that can be seen by the production technical folks, they would much prefer to fix the system once and not have to continually fix individual cases.

So, I can assure you that that is happening at a really high level. Now, whether or not what you’re talking about with APTC I just don’t know. I haven’t heard anything about that at all.

MS. BEAUREGARD: Do any other TAC members have questions related to enrollment and recertification, issues with coverage more generally?

We can move on to the next section which is the 1915(c)waivers, and transportation is something that we’ve discussed in these meetings before and it’s obviously a major barrier.

And I know that, Pam, you were working on something. And, Arthur, you also had
something that you wanted to share related to 
transportation. What order would make the most 
sense? Who wants to talk first?

MS. HOFFMANN: This is Leslie.
I’m making sure that Pam is back on. She was having 
some difficulties. Just a second.

MS. BEAUREGARD: Okay. Thank 
you.

MS. HOFFMANN: She wants to 
know if you have a dial-in number. She’s having 
trouble getting back in and hearing. Is there a 
dial-in at the top of the agenda? I can’t see the 
top from here.

MS. BEAUREGARD: I always went 
to the TAC page.

MS. BROWN: The TAC page lists 
the dial-in number for the meeting. I just put it 
up and so did Emily.

MS. BEAUREGARD: Thanks,
Miranda.

MS. HOFFMANN: Thank you.

MS. BEAUREGARD: Arthur, do you 
want to wait until Pam is back on to share your 
comments?

MR. CAMPBELL: Yes.
MS. BEAUREGARD: Okay. Why don’t we, while we’re waiting on Pam, we can go down to the next section since she’s going to be the one to best answer anything about the waivers.

So, our New Business, we have a question here - how can or how will Medicaid enrollees be able to access free over-the-counter COVID tests? Is there anyone on from DMS who can answer that question?

MS. PARKER: This is Angie. I’m looking to see if I can find an email on that, but Dr. Fatima Ali, our Pharmacy Director, would probably be the best person to be able to answer that.

MS. BEAUREGARD: Okay. Even if we could get the information via email after this call, I think that would be helpful; but our understanding is that Medicaid enrollees should be able to get free over-the-counter tests but we just don’t know exactly what that process looks like, what we can tell people.

MS. GUICE: I’m sorry. I had to take a call from the Secretary’s Office, so, I didn’t hear this part of the conversation and I apologize.
They should be able to go to the pharmacy and get them over the counter, right, Dr. Theriot?

DR. THERIOT: I think they can get up to four tests and there’s a standing order out there that any Medicaid member can go and get the test at the pharmacy.

MS. BEAUREGARD: Is there information that’s shared with Medicaid enrollees about that?

DR. THERIOT: I don’t know the answer to that.

MS. BEAUREGARD: If there is something, whether it’s a letter or----

MS. GUICE: It probably wouldn’t have been a letter from us. It probably would have come from the MCOs.

MS. BEAUREGARD: So, we have MCO representatives on today. Are you all aware for your own MCO if something has gone out to members related to over-the-counter tests?

MS. ROSS: This is Tabita from WellCare. Let me just check with our Pharmacy Director and I’ll get right back with you.

MS. BEAUREGARD: Thank you.
MS. PARKER: This is Angie with Medicaid. I found the email. DMS will cover all FDA-approved home tests through the pharmacy benefit. This includes both prescription and OTC tests. DMS will place a limit of eight tests per member per month. DMS will contain costs and incentivize these cost-effective options.

We have a set effective date of 1/15/2022 for those changes. So, this was on 1/20.

MS. BEAUREGARD: Thank you. Is that an email that was just internal?

MS. PARKER: Yes. It was just internal.

MS. BEAUREGARD: We would love to share the information and really encourage people to use that benefit if there’s information that you all have that we can share on your behalf.

MS. PARKER: Yes. MCOs are to send member communication and DMS and MedImpact will be updating websites and asking MCOs to do so as well.

MS. BEAUREGARD: Great. And because this is a universal formulary or a single, it would all be the same process? It wouldn’t be
different from one MCO to the other?

MS. PARKER: It would be the

same. The information would be the same, yes.

MS. BEAUREGARD: Okay.

MS. PARKER: As you know,

MedImpact is the Pharmacy Benefit Manager.

MS. BEAUREGARD: Yeah. That

makes a big difference.

I think that answered my

question, although it would still, as I said, be
good to get the information that we can share so
that people are aware of the benefit and we could
just be helpful and kind of promoting it.

Was there any other New

Business before we go back to the waivers?

Does anyone know if Pam has

been able to join?

MR. CAMPBELL (By Interpreter:)

He asked if you all wanted him to read what he has.

MS. BEAUREGARD: Arthur, I

would like for you to read it. I just feel like Pam

should be here to have that conversation.

MR. CAMPBELL (By Interpreter:)

He said if Ms. Smith was not in this meeting, then,

he suggests that we table this issue until Ms. Smith
is with us.

  MS. BEAUREGARD: She was here earlier and I’m hoping that she can re-join us. We may just need to give it a few minutes because I know this was something we tabled from the last call.

  MR. CAMPBELL (By Interpreter:)
  He said may he read what he has?
  
  MS. BEAUREGARD: Anyone from DMS, can you give us an update on whether you think that Pam is going to be able to call in?

  MS. GUICE: Checking on it.
  (Long pause)

  MS. CLARK: I just spoke with Pam and she is trying to get reconnected right now. She is having a lot of Internet problems.

  MS. BEAUREGARD: Thank you for checking. We’ll just give it a few minutes. We’ve covered everything but our recommendations. Let me look at the time. We have plenty of time. So, let’s just give it a few minutes and see if Pam can join us.

  (Long pause)

  MS. BEAUREGARD: While we’re waiting, we could do recommendations if people would
like to go ahead and do that.

There’s one that I had brought up when we were talking about network adequacy which would be - I think this is how I would phrase it- when an MCO member contacts Customer Service regarding the availability of a provider, we recommend that the MCO representative be required to disclose the network adequacy rules that they are required to meet up front in order for the Medicaid member to understand the process for getting an out-of-network provider approved.

Does that seem clear or is there another way we should phrase it?

MS. BROWN: Can you repeat it?

MS. BEAUREGARD: When an MCO member contacts Customer Service regarding the availability of a provider, the Consumer TAC, we recommend that the MCO representative be required to disclose the network adequacy rules they are required to meet up front in order for the Medicaid member to understand the process for getting an out-of-network provider approved.

MS. BROWN: That sounds good to me.

MS. BEAUREGARD: Anyone else
have thoughts on that?

MS. JACKSON: This is just the request, right?

MS. BEAUREGARD: Right. We make a recommendation to the MAC, to the Medicaid or Medical Assistance Advisory Council. And, then, if they accept that recommendation, then, DMS is required to respond to it. It doesn’t mean that they have to agree with it and also make that change, but that’s the way, as an Advisory Council, the MAC operates.

So, they make those recommendations and, then, DMS will respond with whether or not they will make a change or kind of explaining why a change can’t be made, that sort of thing.

Well, then, I will ask for a motion to approve that recommendation and a second.

MS. BROWN: I motion to approve the recommendation.

MS. BEAUREGARD: Thanks, Miranda. Anyone second?

MS. JACKSON: I can second it.

MS. BEAUREGARD: Thank you, Christine. All in favor, say aye. Any opposed?
That motion carries. So, we will make that recommendation to the MAC at the March meeting.

And, then, I wanted to ask if there are any other recommendations that people would like to put forward?

MS. BROWN: I think that in the past, we already made a recommendation about removing the five-year waiting period for pregnant women, right?

MS. BEAUREGARD: You know, I think that we did, Miranda. I can’t remember what month we made that recommendation but I don’t think that there’s any reason we couldn’t do it again.

MS. JACKSON: It might have been the month that we lost our meeting notes.

MS. BEAUREGARD: That’s possible. I actually feel like it might have been even before that.

I actually took my own notes from the November meeting, Christine, and now that I’m thinking about it, we didn’t make any recommendations. We did make one recommendation in December and we do have minutes for that.

So, luckily, we didn’t have recommendations that got lost, but I couldn’t for
the life of me tell you what month we made the recommendation.

        MS. BROWN: I looked back in my notes and it was September of 2020 that we made a recommendation on removing the five-year wait for pregnant people.

        MS. BEAUREGARD: Do you have the response from DMS by any chance?

        MS. BROWN: That I will also have to look for.

        MS. BEAUREGARD: Well, we’ll look for that, and if Pam can’t join us by then, Arthur, at that point – oh, it looks like Pam Smith is here.

        MS. SMITH: I’m here. I’m hoping that my connection is going to hold.

        MS. BEAUREGARD: Well, then, Pam, we will immediately go back to the 1915(c) waivers. Thanks for rejoining us. I’m sorry that you’re having trouble.

        MS. SMITH: I am so sorry.

        MS. BEAUREGARD: No. It happens. Sometimes it’s unavoidable.

        Arthur has something that he would like to read and, then, we wanted to get any
updates from you. So, Arthur, why don’t you go ahead.

MR. CAMPBELL (By Interpreter:)
He says I want to apologize to Pam Smith and P&A for not doing what I said I was going to do. I was supposed to ask people with disabilities if they needed an accessible public transportation across the state.

Also, I was supposed to find out what each Medicaid waiver will and what it will not pay for in transportation but I didn’t do this. Pam and I was supposed to discuss this important need; but if Pam is not in this meeting, then, I suggest that we table the issue until Ms. Pam is with us.

Besides medical transportation, people out in the rurals are desperate for accessible transportation. We need transportation like able-bodied people have----

MR. CAMPBELL We need----

MR. CAMPBELL (By Interpreter:)
He is you saying we need transportation like able-bodied people have, but accessible transportation, it is so costly that we can’t afford it or there isn’t any at all and there is no accessible
transportation across the county lines. We need to
find out what each waiver will pay for.

MR. CAMPBELL: Yeah. Thank you
for making that statement.

INTERPRETER: Do you want me to
send it to you?

MR. CAMPBELL: Yeah.

MS. BEAUREGARD: Arthur, I
think it would be helpful if you could send that to
the TAC members as well as Pam Smith.

MR. CAMPBELL: Okay.

MS. BEAUREGARD: Do I
understand you, you wanted to know what each waiver
will cover regarding transportation?

MR. CAMPBELL: Yeah.

MS. BEAUREGARD: Okay. So,
Pam, can you give us an update on where things are
with transportation for each of the waivers? Did we
lose her again? It looks like we did. Erin, do you
see her on here? Okay.

Well, Arthur, why don’t you go
ahead and send that to the TAC members and to Pam
Smith and include Erin, of course. And, then, we’ll
see what information she can share with us over
email but we’ll have to put this, I think, on the
next agenda, unfortunately, the April agenda.

Is anyone else on here from DMS who can answer these other two questions about the HCBS spending plan? Okay. Well, it sounds like we may just have to hold all of those questions.

Thanks for putting that in the Chat, Arthur.

MR. CAMPBELL (By Interpreter:)

I’m sorry that it is poorly written. He said he’s sure sorry that it was poorly written out.

MR. CAMPBELL: Yeah.

MS. BEAUREGARD: Well, I’m sorry that we can’t cover this whole section, Arthur, but we will put it on the agenda; and if we can get any information between now and then from Pam Smith or anyone else at DMS, that would be great.

And, then, I see that, Miranda, you put the response to our recommendation in the Chat. So, thank you for pulling that up. It sounds like DMS said that they were going to conduct a fiscal impact study and we haven’t seen or heard the results of that. So, is anyone at DMS able to share?

MS. HOFFMANN: This is Leslie.
I think I’ve got Pam on now. Do you want to see if you can hear her? I think I’ve got her connected with two phones. Pam, do you want to see if you can speak?

MS. SMITH: Are you all able to hear me?

MS. BEAUREGARD: Yes, we can hear you, Pam.

MS. SMITH: Okay. So, Arthur, first, thank you for that. I was able to hear what you said.

And, so, there’s a couple of things that have happened that I want to share with you. Transportation, I’m still working on what the final solution is going to look like.

Our plan is to put a transportation stand-alone service in all the waivers as we do the rate study and we do waiver amendments.

But in place of that to address the need right now, I don’t know if you have been able to see yet but we sent out a communication and we moved the traditional attendant care service in HCB, we made it available as PDS. It’s going to replace Home- and Community Supports. That includes
the rate. So, it will allow you to pay your
attendants now up to $6 a unit instead of $2.88 a
unit. That’s effective on March 1st.

We’re working with the FMA’s
right now to let them know exactly what they need to
do to help individuals navigate that change and to
do the modifications to the plan of care; but as
part of that service, transportation can be
provided.

So, to meet the immediate
need, individuals can provide transportation under
the attendant care service. Your service advisor
would just need to make sure the plan of care
captured that information.

So, whether that is them
taking you out in to the community for a
socialization type event or whether it be going to
the doctor’s office or going to the grocery store or
to what other errands that you would want to do,
they just need to address that on the plan of care.

So, more information will be
coming out specifically to the service advisors so
that they can help all the individuals to navigate
that change.

MR. CAMPBELL (By Interpreter:)

-59-
He said may he ask how much would that be an hour?

MR. CAMPBELL: Yeah.

MS. SMITH: It’s up to $24 an hour would be the maximum. It’s the same as for a traditional provider. Now, Arthur, you have anywhere in that range up to the max of $24 that you could set as the rate.

MR. CAMPBELL (By Interpreter:)

If an aide was working for an agency, will that agency pay the aide? How much will they pay an hour - will they pay the aide and how much an hour?

MR. CAMPBELL: Yeah.

MS. SMITH: So, the traditional agencies, Arthur, they kind of determine that. The service advisors, when you participant direct, if you participant direct your services, there’s certain taxes and things that come out.

So, the service advisors will help navigate that. I will say I’m not even the best person to answer the question about that, but you will be able to determine what rate you want to pay.

And you have that full - you have the discretion that if there was somebody maybe that worked for you more or that did more for you,
you can work with the service advisor and pay them a
higher rate than maybe somebody that didn’t work for
you as much or maybe didn’t do as much for you.

But if you have questions, you
have my email. Reach out to me and we’ll walk you
through it, okay?

MR. CAMPBELL (By Interpreter:)
I have many more questions but we don’t have time.

MS. SMITH: Arthur, if you send
me of some times that you can talk, then, we’ll work
on setting something up so that I can answer the
other questions, okay?

MR. CAMPBELL: Will that policy
be sent out?

MS. SMITH: Yes. There is
going to be more information coming out in writing,
yes.

MS. BEAUREGARD: Pam, you said
that you had sent out or Medicaid had sent out a
communication. Did that go just to providers or to
waiver participants? Who does that go to?

MS. SMITH: The initial wave, I
think, just went to providers, but Kelly, our
communications person, was working on----

MS. BEAUREGARD: People may

-61-
need to mute their lines if they’re not talking.

I’m not sure what that is.

MS. SMITH: Leslie, do you want to mute, too? It looks like I got back in.

MS. HOFFMANN: Okay.

MS. SMITH: Can you all hear me?

MS. BEAUREGARD: We can hear, or we were hearing you. I don’t hear you now.

MS. SMITH: Can you all hear me now?

MS. BEAUREGARD: Yes, we hear you, or we did. I heard you for a split second.

Pam, if you----

MS. SMITH: Can you hear me now?

MS. BEAUREGARD: Yes, yes.

MS. SMITH: I think we were all kind of unmuting me at the same time and we were muting and unmuting me.

It went out high level to the PDS providers but we are sending out – Kelly was working on the information to go out to the broader HCB population.

And, then, I’m going to be

-62-
meeting with the FMA’s to walk them through what they need to do because it’s effective on March 1st. So, we’re working with the FMA’s to help them be able to modify the plans of care and to understand exactly what they need to do and the conversations, the team meetings they need to have with the individuals.

MS. BEAUREGARD: Okay. That’s really helpful. Thank you. And it’s a great change. So, we appreciate you working on that.

MS. SMITH: It was well-needed.

MS. BEAUREGARD: There were two other questions here related to the HCBS spending plan, the time line and the feedback that you’ve gotten. Do you have more information to share there?

MS. SMITH: I do. We actually yesterday afternoon received our full conditional approval from CMS on the spending plan. Everyone’s is conditional because you’re only approved as long as you meet the guidelines that they had set out and we have to do reporting every quarter. So, they also approved our first quarter reporting that we did. So, the rate study will be
kicking off this month. So, there’s going to be a whole lot more information starting to be shared about that.

Our communications work stream met and we’re going to develop a page just for the ARPA activities where there will be more information so it doesn’t get caught in a lot of the other communications. It’s easier to see.

I can share the initial feedback we had, the initial feedback we’ve had from consumers and providers but we’re getting ready to ramp that back up or we’re going to start - now that we have more information to share, we’re going to start having those meetings again.

So, I can send that over. It was a lot of what we talked about in general. So, it may be more beneficial to wait until we start having those meetings and give the providers and members and advocates time to kind of hear where we’re going specifically and to kind of see what’s going on.

MS. BEAUREGARD: I think that makes sense if other people are okay with waiting for feedback once those sessions start again.

So, just to clarify, Pam, one,
it’s great that you finally got that conditional
approval. I know it’s been a long time coming.

MS. SMITH: You’re right. I
was a little nervous.

MS. BEAUREGARD: Was it
anything different from what you proposed?

MS. SMITH: No.

MS. BEAUREGARD: Everything was
approved.

MS. SMITH: They did. And,
honestly, the questions that they had asked us in
the Request for Additional Information were more
clarifying questions. It wasn’t that they really
had a problem with anything that we did or had a
concern. It was just they wanted to be sure they
understood exactly what the plan was.

We have a lot that we are
looking forward to getting started. We have been
having a lot of meetings in between, in January and
so far in February with the planning and getting
things up and going.

And, so, we’ll start engaging.

People will start seeing more meetings and more
engagement towards the end of this month and the
beginning of March.
MS. BEAUREGARD: Okay. That sounds great.

Arthur or any other TAC members, do you have additional questions for Pam about the 1915(c) waivers or issues to share?

Pam, thank you for making all those efforts to get back on. We really appreciate it.

MS. SMITH: Thank you all for being so patient.

INTERPRETER: Ms. Pam, Arthur has got a question.

MR. CAMPBELL (By Interpreter:) Is the policy for five years?

MS. SMITH: So, Arthur, that rate will remain in effect until the rate study is done. And as part of the enhanced FMAP, I can guarantee you that the rate will not go below that.

MR. CAMPBELL: Thank you.

MS. SMITH: You’re welcome.

MS. BEAUREGARD: Thanks again, Pam. Arthur, I think this is good information to have. And if you have anything that you want to add to the April agenda for follow-up, just let me know, but it will be good to have that rate study kicking
off now, too. I think that will make a big
difference.

One other thing that we had
just started talking about before Pam got back on
was the September, 2020 recommendation that the
Consumer TAC made, and it sounds like the response
from DMS was that they were planning on doing a
fiscal impact study to look at the fiscal impact of
lifting that five-year bar for legally-residing
pregnant women and what that would cost to cover
that additional population.

So, is there any information
that you all can share with us today about that
study?

MS. HOFFMANN: This is Leslie.
We may have to get back to you on that one.

MS. BEAUREGARD: Okay. If you
don’t mind looking into that, Leslie, that would be
great.

MS. HOFFMANN: Yes. I’ll make
sure that that gets followed up on.

MS. BEAUREGARD: I appreciate
it.

With that in mind, Miranda, do
you want to go ahead and make any other
recommendation or wait until we have the results of that fiscal impact?

MS. BROWN: Good question.

Does it make sense to just recommend a fiscal impact study?

MS. BEAUREGARD: Yes. I mean, I don’t think it hurts. The response would be, well, we’ve already done one or we never got around to it. So, if you want to make that recommendation.

MS. BROWN: Okay.

MS. BEAUREGARD: You tell me what you want it to say.

MS. BROWN: That we as a TAC recommend that DMS conduct a fiscal impact study to determine - I’m trying to see how to word it----

MS. BEAUREGARD: How about related to lifting----

MS. BROWN: Related to lifting the five-year bar for pregnant women who are considered legal, permanent residents.

MS. BEAUREGARD: Okay. That sounds good. Do you want me to read it back?

MS. BROWN: Sure.

MS. BEAUREGARD: We recommend DMS conduct a fiscal impact study related to lifting
the five-year bar for pregnant women who are considered legal permanent residents.

MS. BROWN: I’m just wondering if we should word it more general? That’s how it is stated in their response but----

MS. BEAUREGARD: I’ve always said legally-residing pregnant women but I don’t know if that’s semantics or not.

MS. BROWN: I wonder if we should just use the term qualified, pregnant women who are qualified----

MS. BEAUREGARD: Immigrants.

MS. BROWN: ----otherwise qualified immigrants under Medicaid, yeah, because there are other statuses that would be subject to this five-year wait that would be otherwise Medicaid eligible.

MS. BEAUREGARD: Who are considered otherwise qualified immigrants under Medicaid?

MS. BROWN: Yes.

MS. BEAUREGARD: Okay. I think that makes sense.

And just again for background for our new TAC members, the Affordable Care Act
gave states the option to lift this five-year bar.
So, if you are an immigrant, typically, even legally
residing, well, yes, only legally residing, you have
to wait five years from the time you come to the
United States to be eligible to apply for Medicaid.

   So, you could be eligible in
every other way but you just haven’t lived in the
U.S. for five years and, therefore, you can’t enroll
in Medicaid.

   Now, the Affordable Care Act
gave states the option to lift that five-year bar
for children and for pregnant women. In Kentucky,
back in 2014 – I think it happened in 2014 – lifted
that for children but didn’t choose at the time to
do that for pregnant women and we’re still
advocating for that.

   So, we know that when pregnant
women get covered, of course, they have healthier
pregnancies, healthier babies and their babies are
more likely to have coverage, too. So, that’s kind
of the background behind that one.

   So, I will read it again and
ask for a motion to approve and a second. We
recommend DMS conduct a fiscal impact study related
to lifting the five-year bar for pregnant women who
are considered otherwise qualified immigrants under Medicaid.

MS. HOFFMANN: This is Leslie. I’m just double checking. You’re going to send that through as a formal request, correct?

MS. BEAUREGARD: That’s right, Leslie. I mean, we still want to know if you’ve already done the - if you’ve already done it, of course, just having the results would be great, but we haven’t gotten that since we made this recommendation in September, 2020.

So, we’re just going to make this in the event that maybe it didn’t actually get completed.

MS. HOFFMANN: Okay. Thank you.

MS. BROWN: So, I can make a motion for that recommendation.

MS. BEAUREGARD: Thank you, Miranda. A second?

MS. JACKSON: I’ll second it.

MS. BEAUREGARD: Thanks, Christine. All in favor, say aye. Any opposed?

All right. The motion carries.

Do we have any other
recommendations before we wrap up today?

Any other items that people
would like to discuss at our next meeting? Of
course, I’ll send out an email in advance but if you
have something on your mind now.

I did get an email from
someone who is a midwife - I’m trying to find the
e-mail. I’m not going to find it right now - and
wanted to bring up an issue related to midwives and
being able to provide those services and bill for
them under Medicaid.

And, so, I will be adding that
to our April agenda just so everyone knows.

And if you have other thoughts
for the agenda or other questions in the meantime,
just let me know. I will make note of those.

The last item on our agenda is
just a reminder about our meeting schedule. So, you
can see the dates for our upcoming TAC meetings.
And, then, I believe I put those on our calendars
this time. So, hopefully that helps.

And, then, there are the 2022
MAC meetings which I am required or I attend those
meetings so that I can report for the MAC for our
TAC. No other TAC members are required to
participate but they are open meetings and you’re welcome to join. And they’re also now being streamed and shared on YouTube. So, if you miss any of these meetings, whether it’s a TAC meeting or a MAC meeting, you can watch those on YouTube which is really great.

So, that’s it for our agenda today, and I can never remember if I take a motion to adjourn. I’m guessing that we don’t necessarily do that.

MR. CAMPBELL: I make a motion.

MS. BEAUREGARD: Thank you.

MS. BROWN: I second.

MS. BEAUREGARD: And seconded by Miranda. Thank you. All in favor, say aye. Any opposed? All right. The motion carries. We are adjourned.

MEETING ADJOURNED
1. Welcome & Introductions: Ms. Beauregard welcomed everyone to the meeting and introductions were made. A quorum was present.

2. Approval of December minutes: The December minutes were approved.

3. Old Business:
   a. What more has been done to address issues Kynectors have reported since our December meeting? Ms. Guice stated that DMS addressed those issues as it stepped through them and she was hopeful that all the bugs have been fixed. Ms. Brown spoke about problems with Emergency Medicaid cases that do not show results at the end and it will say the case is pending a 30-day review. If DCBS is called, the response is that they do not see an application. Ms. Guice stated this would be a technical issue that DCBS needs to report to DMS, and Ms. Guice asked Ms. Brown to send her a screen shot the next time this problem happens. Ms. Beauregard spoke about problems with name changes and Ms. Guice explained how the system works. Ms. Beauregard will re-send Ms. Guice examples from the Kynectors who have experienced these problems.
   b. What updates are there on the development and dissemination of a document explaining the difference between Presumptive Eligibility and Emergency Time-Limited Medicaid? Ms. Guice stated that this is still under review and she did not know when it would be available for others to review. Ms. Beauregard stated that the TAC would like to review a draft in order to give feedback to DMS and would keep it confidential amongst TAC members.
   c. What is the status of the diagram DMS is drafting for Medicaid/KCHIP eligibility? Ms. Guice stated that DMS is reviewing a chart from another state that will be put in DMS’ annual report and this should be ready to review by the TAC within the next several weeks.
   d. What is the status of adding monthly Medicaid/KCHIP enrollment reports to the statistics’ page? Ms. Guice stated she has asked for these to be added but she has not checked to see if they have been.
   e. What is the status of amending the State Plan to lift the 5-year bar on covering legally-residing pregnant women? Ms. Guice stated she was unaware if a decision has been made by leadership and noted that if Ms. Cecil is able to join the meeting, that this can be addressed with her.
   f. What is DMS doing to ensure network adequacy requirements are met? What can an enrollee do if their MCO is not meeting those standards? It would be helpful to have a one-pager/decision tree that breaks down the steps to take with an MCO versus with DMS. Ms. Parker stated that to ensure network adequacy requirements are met, each MCO submits a quarterly report that is reviewed by DMS personnel but that there are challenges sometimes with certain areas for MCOs to acquire contracts, and she stated that DMS also reviews complaints. Ms. Parker spoke about the time and distance rules that should be followed and that MCOs are to work with the enrollees to find the needed services. Ms. Beauregard stated it would be helpful if Member Services’ personnel would inform enrollees up front about what is required in order to get an out-of-network provider because the majority of enrollees do not know the time and distance requirements and she noted that this may be a TAC recommendation to the MAC.
   g. What is the status of the Health Disparity and Equity TAC? Ms. Parker noted that DMS is waiting on one more application and then it will be sent to the Governor.
4. Medicaid Enrollment and Recertification:
   a. How many Kentuckians are currently covered under traditional/expanded Medicaid? How many are covered under Presumptive Eligibility? Ms. Guice stated there is 1.66 million total members and 1,600 members are in PE.
   b. How many Kentuckians were covered under PE Medicaid in February 2020? And/or on average per month in 2019? Ms. Guice has made a data request to get this information.
   c. How many current PE enrollments resulted from applications that were submitted via 1) the public-facing portal; 2) providers; and 3) DCBS? Ms. Guice has made a data request to see if that information can be obtained. She noted it would be helpful to get the agenda in a timely fashion in order to obtain information like this.
   d. What is the timeline/process for incorporating Emergency Time-Limited Medicaid pre-application/pre-approval into Kynect? Ms. Guice stated that the timeline has been designed and is ready to go but not until DMS is able to unwind the maintenance-of-effort requirement. She also noted that if anyone is having trouble getting Emergency Medicaid approved to reach out to her for assistance.
   e. How can MCOs, providers, and community partners work with DMS to educate Kentuckians about the MOE and the redetermination process/timeline? Ms. Guice stated that DMS has some facilitation assistance now to put together a communication strategy plan and it will be asking for input from the community as well as MCO partners to come to the table and help create and work on the plan with DMS. She listed Ms. Beauregard’s and Ms. Brown’s names as participants but noted that any member of the TAC is welcome to join in on the meetings and can email Erin Bickers to let her know of their interest. Ms. Beauregard asked how many people DMS expects to actively recertify versus passive renewal and the breakdown between Modified Adjusted Gross Income (MAGI) and non-MAGI, and Ms. Guice asked Ms. Beauregard to put that question in writing and add it to the next TAC agenda.

5. 1915(c) Waivers:
   a. Transportation is a major barrier for many waiver recipients. What options are or could become available through each waiver program for transportation assistance? Pam Smith stated she is still working on what the final solution will look like but the plan is to put a transportation stand-alone service in all the waivers as the rate study and the waiver amendments are done. Ms. Smith stated that in place of that and to address the immediate need, a communication has been sent out stating that the traditional attendant care service in HCB is now available as PDS and will replace Home and Community Supports and this includes the rate. It will allow a person to pay their attendant up to $6 a unit instead of $2.88 a unit. Individuals can provide transportation under the attendant care service and the service advisor would need to make sure the plan of care captured this information. This will become effective on March 1, 2022.
   b. What is the status of final approval for the full HCBS spending plan? What is the timeline for implementation? Ms. Smith stated that on February 10th, full conditional approval was received from CMS on the spending plan and the first quarter reporting was approved as well.
   c. What feedback had DMS received from meetings with consumers/providers related to the enhanced HCBS FMAP? Ms. Smith stated that they are getting ready to start having meetings again now that there is more information to share and that it may be more beneficial to wait until those meetings begin before giving feedback to providers, members and advocates.

6. New Business:
   a. How can/will Medicaid enrollees be able to access free over-the-counter COVID tests? Ms. Parker read an email dated January 20, 2022 that stated that DMS will cover all FDA-approved home tests through the pharmacy benefit. This includes both prescription and OTC tests. DMS will place a limit of eight tests per member per month. DMS will contain costs and incentivize these cost-effective options. Ms. Parker stated the effective date was January 15, 2020. Ms. Parker also read that MCOs are to send member communication and DMS and MedImpact will be updating websites and asking MCOs to do so as well.
7. Recommendations for the March MAC meeting: Motions were made, seconded and approved to forward the following recommendations to the MAC:
   (1) The TAC recommends that when an MCO member contacts Customer Service regarding the availability of a provider, that the MCO representative be required to disclose the network adequacy rules they are required to meet up front in order for the Medicaid member to understand the process for getting an out-of-network provider approved.
   (2) The TAC recommends that DMS conduct a fiscal impact study related to lifting the five-year bar for pregnant women who are considered otherwise qualified immigrants under Medicaid.

8. 2022 Meeting Schedule:
   a. Upcoming TAC meetings – April 19th, June 21st, August 16th, October 18 and December 20th
   b. 2022 MAC meeting dates: March 24th, May 26th, July 28th, September 22nd and November 17th

9. Adjournment: The meeting was adjourned.

(Minutes were recorded and transcribed by Terri Pelosi, court reporter, on March 1, 2022.)