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

IN RE: PRIMARY CARE TAC MEETING

HELD AT:

VIA ZOOM MEETING

DATE:
MAY 5, 2022
10:00 A.M.
ATTENDEES:

Mike Caudill, Chairman

TAC MEMBERS PRESENT

Yvonne Agan
Barry Martin
Chris Keyser
Raynor Mullins

Erin Bickers and Veronica Judy-Cecil - DMS

Note: Many more participants were present via ZOOM.
MR. CAUDILL: We can get started at this
time at 10:10. I'd like to call the
meeting to order. And Teresa -- I believe,
Teresa Cooper, you're on here, would you
care to establish the quorum, please?
MR. MULLINS: I'm on Mike. I had trouble
connecting.
(Discussion regarding Zoom connection.)
MR. CAUDILL: Teresa, could you go ahead
and call the roll call to establish a
quorum, please?
MS. COOPER: Yes, sir. Mike Caudill?
MR. CAUDILL: Here.
MS. COOPER: Chris Keyser?
MS. KEYSER: Present.
MS. COOPER: Barry Martin?
MR. MARTIN: Here.
MS. COOPER: Yvonna Agan?
MS. AGAN: Here.
MS. COOPER: You have quorum.
MR. CAUDILL: Okay. All members being
present, go to Item 3, Review and approval
of previous meeting transcript. Has
everyone had an opportunity to look over
the transcript and, if so, is there any
changes or modifications anyone would like to make?

MR. MARTIN: I'll make a motion to approve the minutes as submitted.

MR. CAUDILL: Is there a second?

MS. AGAN: I'll second.

MR. CAUDILL: Second by Yvonne.

All those in agreement please vote, yea.

(Members voted affirmatively.)

MR. CAUDILL: Okay. All those oppose likewise.

(No members opposed.)

MR. CAUDILL: Motion carried unanimously.

At this point there are some things with the agenda that I would like to point out. And one, the standard announcements from the MCOs is amended and that should be added to the agenda for next time, and also recommendations to the MAC.

Under 5H that deals with the MCOs, we will have their announcements at that time. If you look at the reference guide, and this is part of why it's on here, is that it has expired for three of the MCOs. Two of the
MCOs expire either this month or in June, and on one MCO it does not give the expiration date. So if you could, MCOs, would you be so kind to be prepared to update your incentives, Covid incentives as far as expiration date when we call on you under 5H.

Okay. With that being said, let me get back to the agenda then. Under Old Business the first item is the WRAP Workgroup Update. And before we start that, let me say the reason this appears a little different is the recommendation from Barry Martin last time. Well, previously we called it -- it's now in two places. So under 4A is the WRAP Workgroup Update, and then the other part dealing with the reconciliation now will appear under New Business 5D Reconciliation.

So that being said, is Ms. Veronica Judy-Cecil on here? Would you like to undertake to bring us up to date on the WRAP Workgroup Update?

MS. JUDY-CECIL: I'd be happy to. Thank you so much. Good morning to everyone.
The WRAP Workgroup met this week on Tuesday, May 3rd. It was a little bit of a shorter meeting. We continued to work through -- we created a tracking document as we identify issues, some of which we believe to be systemic. We're tracking those issues and working to resolve them as a group to, you know, what we hope to be to the benefit of all providers.

So we walked through a couple of things we were able to take care of after the last meeting and that included some new reports that come out of KentuckyHealthNet. Our plan for those, for the providers generally, is we will be creating manuals and FAQs and webinars to help providers understand the tools that are available to them. The MCOs are also getting ability to report out from KentuckyHealthNet on the WRAP that gets generated from the encounters they submit. That was supposed to go into the live at the end of March -- excuse me, April, but that's been delayed a little bit with testing, so that hasn't happened yet. So we continue to work on those things.
The MCOs were going to try to meet in the interim between meetings, but were unable to do so. The purpose of that meeting was for them -- for all six MCOs to come together and to look at best practices and consistency and, again, work towards providing a better service and resolution of issues for providers. So they are now going to meet in May and our plan is to have the workgroup come back together sometime in June. So that's the current efforts of the workgroup.

MR. CAUDILL: All right. Next on the agenda is 4B, Update regarding return to in-person TAC meetings. Again, Veronica, would you or a member of your department like to go on that one?

MS. JUDY-CECIL: Yes. We were able to -- and I believe Erin is in the conference room right now. We were able to get the system set up for the smaller Commissioner's conference room. It does seat -- it's not huge. It seats around, I think, 15 people at the table and then seats around the walls. So, you know,
certainly what we were hoping is that for some TACs that might be something that they could utilize. The larger conference rooms in Public Health are still not, I think, in a position yet to hold larger audiences. We are -- there was some legislation passed during the session that will govern open meetings, and in particular ones that will be as a hybrid. We're still reviewing that and seeing how that will impact our TAC meetings and our MAC meetings. So, you know, I think if it is the will of the TAC to return to in-person, we will then, you know, take on trying to perhaps look at Legislative Research Commission or find a place that could, I think, accommodate the number of people that may want to attend in person.

MR. CAUDILL: So as far as the Committee members are concerned, what's your all's thought as looking at whether to attend in-person or to be able to attend virtually?

MS. KEYSER: Mike, think is Chris.

MR. CAUDILL: Yes, Chris.

MS. KEYSER: I think my preference -- and
this is just me speaking -- would be to have some sort of hybrid option, if that is a possibility. It's a long drive from Bowling Green to Frankfort just to attend a meeting that's hour and a half, give or take, and then having to turn right back. I will go along with the Committee's preference and certainly if they just want to do in-person and will make that work to the best of my ability. But I certainly like having the option of a hybrid, if that is a consideration.

MR. CAUDILL: Barry, what about you?

MR. MARTIN: I'm the same. It would be nice for, you know, the Medicaid representatives and KPCA representatives to be there. I think in-person would be really nice to be able to communicate one-on-one and have that availability, but also for, you know, people that can't make it on that day because they have something else going on, whether it's in Bowling Green, Whitesburg, or wherever. It would definitely be -- so hybrid would be my preference.
MR. CAUDILL: Okay. Raynor what about you?
MR. MULLINS: I would prefer hybrid. It provides more flexibility and it seems like that's what the group refers, too, so I'm in favor of that.
MR. CAUDILL: Yvonne?
MS. AGAN: I agree with the group. I think a hybrid option would be great. I think being able to get back into some face-to-face sessions would be beneficial. I support the hybrid because sometimes the travel, and some are traveling a distance, can be a hindrance.
MR. CAUDILL: I think we're all in agreement from the Committee members that because of travel constraints, at least in my case, we will -- I will be attending most meetings virtually rather in person because it's a three-hour drive for me each way. But then I'd like to have the option because conceivably there's going to be something coming up that we would want to be there in person and have a more intense interaction between the people.
MS. JUDY-CECIL: I will say that, again,
that we are digging into the impact of the new legislation. We cannot -- if we do a hybrid, it means that in-person location has to be able to accommodate anybody who wants to attend in-person, so we couldn't limit it to just the TAC Members and DMS staff. We would have to make sure that it could accommodate anybody who would want to attend in-person. I think that's kind of been our concern is that's hard to forecast, especially, you know, because we haven't met in person in a couple of years. So we have some sense of how attendance at previous TACs when we were in-person, but not really having an idea of what it would be like once we allow that to happen. So we can work to try to find a location to do a hybrid at the next meeting if that's the desire of the TAC, and then we could keep you updated if we are having any issues with that.

MR. CAUDILL: Perhaps we need to be called on and respond with our intent whether we will be present in person or virtually to help you-all with your planning.
MR. MULLINS: I go saw a note from Molly, I thought, Mike -- I don't know if you saw that -- about hosting.
MR. CAUDILL: Let's see. Yeah.
MR. MARTIN: How many could KPCA hold as far as...
MR. MULLINS: That's what the note is about now.
MR. CAUDILL: Do what?
MR. MULLINS: I believe Molly indicated KPCA would be willing to host.
MS. LEWIS: We can just get together with Veronica and Erin and see if that's an option --
MS. JUDY-CECIL: That would be great. We can work on that.
MS. LEWIS: -- the logistics if that works.
MR. CAUDILL: Okay.
MR. MARTIN: It looks like we have 47 participants right now. Of course, we wouldn't have that many attend.
MR. CAUDILL: Molly, I'm hearing you. You're whispering and open. Do you have something you want to say? I don't mean to cut you off.
MS. JUDY-CECIL: I think she was looking for the mute.

MR. CAUDILL: Okay. All right. So we will let KPCA and DMS discuss that and we can take that up next time then.

Let's go to 4C, the Update on the Provider Signature time, which is the -- that FQHCs and RHCs are required to report on the day of the visit and other entities have three days and the Department's intent to make that consistent at three days.

MS. JUDY-CECIL: I have some good news. We actually did file regulations last week, so they are starting the process. They have been filed and it does take about eight months to get through the entire process, but at least it's on it's way. And then in the meantime I think what we have shared is that the Department is not enforcing that particular provision, so that we can ensure that all the provider types are aligned.

MR. CAUDILL: Okay. That's great news.

MS. AGAN: Veronica, what is the regulation that you are filing for?

MS. JUDY-CECIL: It is 907.1082.
MS. AGAN: Thank you.

MR. CAUDILL: The next thing on the agenda is 4D, Update on same-day visits. Veronica, you are up again.

MS. JUDY-CECIL: So the Department continues to work with its vendor Myers & Stauffer to research in a little more detail how other states reimburse for same-day visits. So they have looked at multiple states, gathered some information, trying to do some modeling, and we did meet with a particular provider to get some information about how they -- you know, it currently works for them for another state where they do have multiple -- reimburse for multiple visits in a day. So we are continuing to work on it and, you know, certainly we will continue to provide an update on, you know, our findings as soon as we have I think more information to share.

(Technical Difficulty)

MR. CAUDILL: Ms. Agan, would you care to repeat your comment? I did not hear and I don't think Veronica was able to hear you
either.

MS. JUDY-CECIL: Is there any questions or comments about that?

MR. CAUDILL: Okay. So we will leave that on the agenda for next time. Then that finishes up old business and we are going to go to new businesses.

First thing is a presentation under 5A, Level of support for primary care, and it deals with the extensive handout that was available to us. I believe that Molly Lewis will be handling that. Is that correct, Molly?

MS. LEWIS: Mike, we're having technical difficulties right now. Can we move that to the next agenda item and come back?

MR. CAUDILL: Sure. Sure. So let's skip to 5B, the Shortage of Dental Services and Outdated Dental Fee Schedules. And that's actually two items. One is a Shortage of Dental Services and the other is dealing with the Outdated Dental Fee Schedules, leaving that as being -- or not being competitive. And I think Ashley Gibson is going to be addressing that.
MS. GIBSON: Yes, good morning. Thank you for having me. I am Ashley Gibson. I am the Workforce Program Manager with the Kentucky Primary Care Association. So as part of my job I work with our members to retain the workforce that they have today, so that's through loan repayment, provision of resources and then initiatives to help plan for the work force of tomorrow and into the future, so working with students and getting pipeline program activities in place to make sure that we have those physicians when needed. And as part of working on our workforce, I am the staff member that gets the call when there is a member that's having a hard time staffing the position. And I'm just here to tell you I'm getting a lot of calls about dental positions. There is a large dental shortage that we are seeing among our members. Right now I have on my list right here 13 dental openings that I've had members call and ask for support with. I reached out to the primary care office that manages the HPSAs, the designated shortage
areas in our state, to see what we are
currently at in terms of dental shortages.

    So they are doing a larger view of the
designations, and right now we have 90
counties designated as dental shortage
areas, so that's 75 percent of our counties.
And I expect once this review is finished
that we may see this number grow. And when
you look at the map and once that map is
finished and they finalize that review, I'm
happy to provide that. You will see it's
very distributed into our rural areas and
into the corners of our state, because our
two dental schools are in Lexington and
Louisville. So many, many of our members
train students, many of our members are
training dental students, but even at that
it's not enough and even -- you know, again,
I hear these stories from my members. I
just heard yesterday of a dental student in
their last year that's under contract with a
member that's being poached because it's
just that competitive.

    So I'm just here to serve as a
resource. I put my e-mail in the chat. And
if there's anything we can do together to try to increase the dental work force, I'm happy to -- happy to help with that. And I just want to make sure to add -- I know I spoke mostly about dentists, but the shortages go past dentists into dental hygienists, dental assistants. We are just seeing a large shortage of dental providers overall within our state. And I'm happy to answer any questions, and I think -- I think Teresa was going to maybe talk about the dental fee schedule if she's able to.

MR. CAUDILL: Before we get into the fee schedule, let's see if there's any questions concerning the shortage. Raynor, I would think that this might be something you want to weigh in on.

MR. MULLINS: Yes, I'd be happy to make some comments. I feel like I've spent 40 years working on this problem and it's getting worse, so I don't know what that says about my contributions, but there's no doubt that that's the case.

When I think about this I separate it out into several categories, the first being
the practicing dental profession, the second being the safety net programs like community health centers and public health departments, the third being medical and dental education problem, and the fourth being problem with managed care policies and the incentives and reimbursements.

And I further tend to divide it -- I go back to what we used to call the dental education wars of the 1980s and 1990s. In the early 1990s the state through official policies of Council on Higher Education and legislature capped in-state dental enrollment, and they specified it to be 36 with the University of Kentucky and 44 at the University of Louisville, and they opened up out-of-state enrollment. And that essentially put us down the road to privatization and that's the genesis of a lot of the shortages that you are seeing today. So there probably needs to be at higher levels an examination of enrollment policies and incentives in the funding of dental education in the state. So that was the root cause and we are just now -- I
don't know why I'm picking up --

MR. CAUDILL: Molly, I'm seeing that you're not muted. Okay. Now try it, Raynor.

MR. MULLINS: Okay. So that was the -- that's the root cause and this has been years, decades in the making and it's just -- it's now reached a crisis stage.

Now, when you look at the practicing profession, this is a result of the profession's desire to stay separate and apart from the basic medical care system. The only place you really have integration is in the community health sector where you have co-location of services. And so what we have now in Kentucky, and I tend to separate this out into general dentists and dental specialists, is you have only -- the last time I looked at it and this needs to be updated. And, Veronica, I know in particular there's been efforts to try to share Medicaid data with the University so they can do some further study of this problem, and I don't know where that stands, but I would like to see that really reactivated again, because we're kind of
flying blind without current information on this.

But going back to the issue of private practitioners participation. When I looked at it the last time, there was only 400 of 2,000 practicing dentists in Kentucky actually participating in the Medicaid program. That's about 20 percent and that's at any meaningful level. I know what the registration shows. It shows up 800 or 1,000, but that's a very misleading figure, because the actual participation is far, far less than this and I believe that could be verified.

That gets further compounded when you look at the specialists who are in short supply anyway. They do participate at much higher levels, but their capacity is limited because their numbers are limited. So what you are seeing is the outcome of this -- these two factors have combined that there's real shortages.

Now, on the dental education side again, going back, the students are graduating with heavy levels of educational
debt, and so tying it back to the reimbursement issues and managed care, many of them don't see that it's economically viable to practice in the shortage areas in rural Kentucky. That's as simple as I can put it. And the corporate providers are paying much higher bounties to help them reduce their educational debt, or they are going out of state. And so it's a real -- it's a longstanding problem that has many aspects to it. It's not a -- there's not a simple solution.

Governor Beshear actually asked me to work on it -- this is the first Governor Beshear, Steve Beshear -- and we did rather exhaustively and came up with a whole set of documents and policy recommendations, and we were well on our way to trying to address some of these in a substantive way when Governor Bevin cancelled -- cancelled all of it, when you had a change of politics. So politics has been the primary reason I believe that we are in this situation we are in.

And I'll just stop. But I'm happy to
elaborate on this, but this thing has been studied to death. We have mounds and mounds of information about the nature of the problem. We know that the dental reimbursement rates are out of date and that there have been means and -- and millions, you know, carved off the dental budgets. So this is a major -- it's a major issue. It's not going to -- there's no simple solution. It's going to take some long-term policy revisions and some revisiting of a lot of things. And with the support now for higher education and education in general in Kentucky, I don't -- you know, I'm pretty pessimistic about the -- you know, where we might be able to go, but at the same time you don't not work on it. You know, you go back and you try again.

And I will have to say that most of the access to dental care among the general dentist community in Kentucky is now being provided through the Primary Care Association, a good portion of it, significant improvements in access. And the association has made a tremendous effort to
improve its dental services, but it's still a major problem because they only represent a small fraction in all the practicing dentists in the state of Kentucky that could actually help with this problem. We know what works. We just haven't implemented it in Kentucky, so I'll stop.

MR. CAUDILL: When you say we know what works, what would that be?

MR. MULLINS: Prevention works, increase use of auxiliaries work, care coordination works. Higher reimbursement rates to some extent marginally work, but they usually don't pull in any more dentists into the participating group. They just maintain the group that you have got. Loan forgiveness works. The integration of care in co-located sites works. All of those are options that we know work, Mike, but we haven't found the will to fund programs appropriately to apply those things in practice. And we made starts and then we stop and we recycle, and we start and we recycle and we start and we recycle. And we were making a pretty concerted effort
under Governor Steve Beshear with public
health dental hygienists and health
departments and primary care centers to
actually try to implement some of these
policies and, you know, it all got wiped
out, or most of it got wiped out. And we
know the situation that our health
departments have been in with the, you
know, retirement funds and the crisis that
they faced in funding before Covid hit, and
to some extent that's been relieved and,
you know, they are funded a little bit
better now, and I don't know how that will
be for the long term. But dentistry has
always been a stepchild with mental,
behavioral health, in terms of how it's
been addressed. And I don't mean to -- to
cry about that, but the reality is
that's -- that's been the situation in
terms of funding. I'm happy -- I don't
want to bore the group, but I mean that's
the realistic assessment of kind of where
we stand, I think. It's going to take
money to correct some of the problem, and a
lot of the issues are going to take
long-term reversals of current policy
before you're going to see any improvement.
You can work on it on the margins and we
should.
MS. KEYSER: Mike, this is Chris. I have a
question. Actually, my question is for
Ashley from the KPCA. Is she still on?
MS. GIBSON: Yes, I'm still on.
MS. KEYSER: You mentioned the two dental
schools in Kentucky. Has the KPCA, you
know, contacted the schools? I guess I'm
curious, one, how many licensed dentists
graduate from their programs, whether is it
annually or, you know, twice a semester?
I'm not quite sure how the school system
works for dentists, so when they come out
and they are ready to practice. And are
they -- you know, what percentage that are
coming out are Kentucky, you know, born and
bred and hopefully will be working in
Kentucky. I guess I'm just curious as to
how that flow of that potential workforce
is looking. Are they -- students that are
graduating, are they from other states and
then they go back to their own states? So
I guess, you know, if that was something that the KPCA knew or could look into.

MS. GIBSON: Yeah, so you bring up a really good point, Chris. I don't have the exact numbers in front of me and that's something I will try to get and share with you-all. But I do know that both of the dental schools in Kentucky take a higher rate of out-of-state students than we would like to see and they do return to their home states. There were some academic politics in play there. Tuition is a little bit higher -- not a little bit, significantly higher for out-of-state students. So we do see a higher rate of out-of-state students coming to Kentucky for dental school and then returning home.

And I wanted to touch on -- Raynor, you mentioned loan repayment as something that works and --

MR. MULLINS: Loan forgiveness.

MS. GIBSON: Loan forgiveness, right. Loan forgiveness. All of our dentists that are in RHCs and FQs are eligible National Service Corps and Kentucky State Loan
Repayment. But one of the issues that we have seen in the last couple of years is they have to be fully licensed before they are eligible for those dollars. And so some members are trying to recruit dentists, obviously, in the last couple of years in dental school, and they can't offer that carrot yet, you know. They are able to say, well, after you are with us for some time, you will be able to apply, but the windows for application aren't matching up with what our members need. And there was some new loan forgiveness payments -- some new loan forgiveness funding that came out of this last legislative session, and myself and Rachel and Doug Hogan met with the team that's going to be managing that, and we raised the issue that it would be nice if they could offer that earlier so members could use that to recruit while they are still in school.

MR. MULLINS: Okay. I'd like to speak to what Chris raised just briefly.

Chris, the last time I looked at it,
at the University of Kentucky the enrollment was in, like, the low 60s and 36 of those were in state, okay, and that's -- for a long time we were at 50, 14 out of state and 36 in state, capped by the state. University of Louisville was capped at a different level. They had 44 in state, but their enrollment was in the 80s, and now I believe exceeds 100 to some extent, and I haven't -- don't have those current figures myself either.

If you'd asked me three years ago, I could have told you specifically, but the proportions are much different. And that's a reflection of the fact that dental education has essentially been privatized using out-of-state tuition. The schools are dependent on generating clinical income from out-of-state tuition to maintain the current -- their current numbers of graduates, and that's the reality and that forces up student debt and that -- that's the vicious cycle that was started. It was a compromise reached to save two dental schools in the early '90s, and nothing's
been changed since then. So that's the reality of what we are living with.

MS. KEYSER: So, Ashley, I saw in the chat -- again, I think we know that dentists and hygienists are eligible to apply for -- through the National Health Service Corps. You know, is that information something that the KPCA, in talking about potential workforce, is communicating to the schools about that, you know, again, consider looking into rural communities or communities that have a high HPSA score for, you know, for shortages for dentists to, you know -- I mean, you know, to at least start their practice. You know, I don't -- I don't know if graduating dentists, you know, who are they recruited by, you know. Established practices who are looking to expand in their state or the state they come from, or, you know -- you know, is there a headhunter for dentists, and if there are groups of head hunters maybe, you know, are they aware of incentives such as the National Health Service Corps too that
they can then share as well when they are looking for dentists. You know, I'm not -- you know, I am not too familiar with the process for, you know, headhunters as there are -- as it relates to physician recruiting, you know, that type of thing.

MS. GIBSON: Absolutely. Yes, that's also a great point, Chris. So, yes, I work especially close with UK. We have a partner there called the Kentucky Medical Professional Placement Services. That gives us access to medical students and dental students. And, additionally, if they move on to residency we are able to work with them, too. And every opportunity I can to talk to dental and medical students, I am always advocating National Health Service Corps, Kentucky State Loan Repayment. You know, talking about the benefits that are available in our health center. So any time I can get an audience, I definitely bring that up. I'd love to be able to get more access to them, but I do at least once a year meet with these groups and talk about loan repayment and the
options.

MS. KEYSER: Yeah, again, just so that the state can appreciate and hear firsthand that there are these shortages because, you know, we all know how dental care and primary care -- you know, as far as if your mouth fails in regard to keeping it healthy, that that can exacerbate, you know, diabetes and other, you know, medical issues as well. And so, you know, Kentucky is trying to improve access to dental and our, what, score of having a state that has a high number of people with no teeth or toothlessness and denturism, we have a high rate of that. You know, we are not going to be able to address that and work on those kind of improvements if staffing issue, workforce issue continues, so...

MR. CAUDILL: Let me step in here then, and there's a second part of this, the outdated dental fee schedules. Was there someone that was wanting to speak to that?

MS. LEWIS: Me. I don't think I'm the person on the agenda to speak to that, but I do think that it's an important thing to
take into consideration, that in addition
to having the workforce stay in Kentucky in
the dental space, it's also -- the next
part of that equation is to the
participation in the Medicaid program.
Right now it's just not very appetizing or
doesn't make a lot of business sense for
dentists in Kentucky to take care of
Medicaid patients. And then the
complications of dealing with
subcontractors of the MCOs, et cetera,
there's a lot of administrative burden and
it's just a low -- if they can fill their
chair with a patient that has commercial
insurance or private insurance versus a
patient who has Medicaid insurance, then
the incentives are pretty clear.
MR. MULLINS: Comment, Raynor. I would bet
my shirt that there is non-equity between
medical and behavioral health and dental
reimbursement among the MCOs, and so I
would -- would bet if an analysis, a
careful thoughtful analysis was done, that
there's not equity among the way
reimbursement is being handled across those
three areas that need to be coordinated in
the primary care sector.

MR. CAUDILL: What I'm seeing here is a
situation -- I know in our organization I'd
like to have available four to six dentists
to hire over the next 12 months, but it's
not out there. And for a lot of factors
it's completely -- the landscape has
changed about recruiting dentists, if you
can find them. And one thing's that's not
at -- is the organizations that have
cropped up where they hired dentists, they
are doing a cash-basis cherrypicking, if
you will, and is taking a lot of the
dentists that you would have available out
of it for joining these type of
organizations. That's just changing
landscape. But what I'm seeing here is I'm
seeing the genesis for a recommendation to
the MAC to undertake, to resolve to -- to
work on this issue and make
recommendations. And I'm not sure exactly
how that should be worded. Perhaps one of
you, perhaps Raynor, might want to see how
we could bring this to the MAC's attention
and ask for their input and upgrading these things. So think between now and the end of the meeting when we get to that part and see -- see if you-all agree that this should be Recommendation to the MAC to undertake this.

MR. MULLINS: Mike, I'll try right away. I'd like to see a recommendation that the MAC work with the Office of Health Policy in the Cabinet and, you know, that -- that's to study that issue and make definitive policy recommendations to address workforce shortages, dental enrollment levels and reimbursement for dental services. In other words, I'd like to see a real good policy effort made at the Cabinet, not just referring it to the MAC, but internally to study this issue just like they have the WRAP.

MR. CAUDILL: All right. So let's go on at this point and then revisit it later in the agenda when we talk about recommendation to the MAC.

Having said that, is the primary care collaborative, Molly Lewis, are you ready to
do that presentation at this time?

MS. LEWIS: Yes. Thank you, Mike. I've got some slides.

(Zoom Sound Issue.)

MS. BICKERS: Molly, you are muted if you are talking.

MR. CAUDILL: Molly, we cannot hear you.

MR. HARILSON: I think they are working on it, Mike.

MR. CAUDILL: Okay.

MS. LEWIS: It won't let me share the slides and talk at the same time. Hold on.

MS. BICKERS: You want to try to e-mail those to me and I can share while you go through them?

MS. LEWIS: Yeah, that would be great. I don't know what that new feature is that you can't talk and share at the same time. Go to share.

Okay, it's coming from Drew to E-R-I-N... See if this works. Did you get it, Erin?

MS. BICKERS: I did. I lost everybody while I tried to get it open. Just a second while it opens.
MS. LEWIS: Thank you so much.

So like I said, we have been talking a lot at the office about primary care, what it is, what the investment is, the way that the contracts are structured, where the incentives are, and just how we continue to live out the mission of the KPCA to improve access to primary care, and there are two reports that we think are really helpful. Okay. So I have my notes if you just want to do just like the full slide show thing.

MS. BICKERS: Can you see it?

MS. LEWIS: Yeah.

MS. BICKERS: Okay, perfect.

MS. LEWIS: If you push slide show, then it might -- it can be bigger, yeah.

Anyway, there you go. Okay, perfect.

Thank you.

Okay. So next. That was just a -- I love the New Yorker cartoons.

So, Erin, I think you have to push it a couple times to get through. As you know, KPCA, we want all Kentucky residents to have access to comprehensive patient-centered care, and it comes down to coming together
as essentially a network of
similarly-oriented providers who have this
initiative, and that's how we try and help
support them.

So you can go through the values and,
then we can go to the next one. I think you
have to click enter a bunch. Just click on
through that.

Okay. So a lot of what we try and do
is create learning collaboratives and then
collective efforts to move forward in that
agenda.

As you know, we were founded in 1976.
Most of our members are either community
health centers, or what's known as federally
qualified health centers, rural health
clinics and then similarly-oriented primary
care providers, which generally are in
underserved areas.

Something that we have done for quite
some time, and it continues to evolve, is we
provide -- one of our member services is for
the members to come together and jointly
contract with payors. And we have moved
from what was the messenger model, which was
a tightly-regulated way where we were just, you know, delivering the message. You know, this is the offer, do you accept it. This is the -- no, this is our counteroffer. To moving towards more of a clinically-integrated network where we have more engagement and more clinical leadership in helping to improve quality and help move the needle.

Okay. Next.

So there is the study that came out a couple years ago and it was by the Primary Care Collaborative and what they looked at were trends in private insurance. So this was for -- they looked at the total spend and it was for all individuals who had private healthcare plans. This was -- they were either fully insured or self-insured and it included also employer-sponsored plans. And what was considered cost or spend was all allowed costs, including copays. And if you -- and if they looked at every state and if -- for Kentucky, for the way that money is spent on healthcare expenses, 3.14 percent was on primary care.
So that meant that 3.14 percent of all the money that was spent on healthcare went towards healthcare services delivered by family healthcare providers, internal medicine, pediatrics, general practitioners, really, but just that M.D., D.O. level of care, and we were 50 out of 50. So that meant Kentucky had the lowest investment in primary care for private insurance.

But if you looked at a broader scope of what primary care is, and you start to think about a more diverse scope of workforce to include nurse practitioners and PAs and then, you know, wider range, we actually did a better job. So we were 22 out of the 50 states. So what we take away from that is that while our workforce and our utilization is limited, if you have a broader scope obviously we do a better job compared to other states.

Next.

So this is pretty interesting. We realized that in that study of the private insured primary care utilization decreased 24 percent from 2008 to 2016. But
specialist visits remained flat or increased, and urgent care visits increased for problem-based care. So what does this mean and how are we -- how are we responding. It seems to mean that the patient the utilization is for primary care is going down and we need to figure out why.

Is there anything else I can help with? You want to add to that?

And you would also think about primary care, you know, there is a limited -- there is less of a workforce. More people were at home, there were shorter essential -- there were stay-at-home orders. A lot of people deferred access to care. But those types of trends didn't apply to specialty care access.

Next.

Then you look at -- and this is just a short -- I mean, this is limited, but it kind of paints the picture. So if you looked at what Kentucky's Federally Qualified Health Centers look like, what their payor mix is like, then the information that we just showed about
private insurance is just about 30 percent, you know, less than a third of the types of patients that are cared for in the underserved areas.

So next.

So we were interested in seeing what the rest of the story is. Safety net providers are what we like to -- our network, the way that the contracts work, they are responsible for 100 percent of the healthcare costs of their patience served. So when you think about where money is being spent and how payments are being -- how payor relationships are working, there's a tremendous responsibility.

Next.

To make sure that the patients are cared for in the most, highest quality low cost or, you know, cost effective way. So what do we need to do? Primary care is proven to be the access point or the gateway for primary care, so patients with the greater primary care spend have less avoidable hospital visits. So we need to have better patient outcomes, greater equity
and more efficient use of healthcare resources, and how do we orient towards primary care to get there.

Next.

So the valued-based proposition, which we talk about all the time, value equals quality over cost, and you can't get -- the way that that's demonstrated or measured, the first thing to do is to control cost and then you're incentivized to deliver higher quality as it's measured.

Next.

But the interesting part is that the United States spends more money on -- U.S. spends its money on healthcare, not health. So we need to change, like I said, the compass of the perspective, because if you look at that person on the left-hand side, what makes us healthy, about 10 percent is access to healthcare, and then so much more of it are other contributions. But we spend -- 90 percent of the costs are on medical services and not very much is spent on preventive or primary, you know, on actual things that determine health.
Next.

And this is just something from a while ago in the Herald-Leader showing here in Kentucky where if you look at access to healthcare in terms of life expectancy, it's greatly determined by where the services are and how they are being delivered. So like, for example, you see life expectancy is 78 in Fayette County, 78 years old; whereas, Wolfe County, which is just an hour east, is 70 years, so what's the difference?

Next.

And this is another part showing that our outcomes, if you look at, for example, premature death or birth weight or adult days of not feeling good, how does that reflect where primary care is being delivered and how it's being delivered. And I guess it's not just where the care is, it's how it's being utilized and where the incentives are to utilize it better. So, like I said, healthcare is more than just about the doctors' visits and has to do with taking care of the whole patient, and we
call these social determinants of health. So much of how we access healthcare, where patients feel empowered to show up, has to do with social determinants of health.

Next.

So while there used to be this concept, and you-all have heard David Bullock say this a lot, treat them and street them, where it was very volume driven; now it's more of a comprehensive approach to make sure that the patient -- that once you get the patient in the door, you deal with transportation, scheduling, making the patient feel empowered to ask questions and access care, you want to really capitalize on that visit to take care of the whole patient during that visit. You can do a lot for a little cost and hopefully avoid some of the bigger costs in terms of hospital visits.

Next.

In Kentucky -- as you-all know the general assembly, when they were asked Medicaid per the spend, I think that Kentucky's numbers show that if you looked
at federally qualified health centers and rural health clinics, it was about 2.9 percent spent on primary care, so that reflects what those private insurance claims data showed as well, so we're not -- we're not spending money on preventative and comprehensive health services that can control and change the narrative for the health of Kentuckians.

Next. You can keep going. It's going to be several things.

So it's just about having better coordinated care, being creative, what do you do to get the patient there, and help take care of them in a compassionate and comprehensive and coordinated way. Things like access, having broader hours of operation, transportation to get there, front desk training so that the patient feels comfortable showing up and making the most of the visit. Having call centers so that the patient doesn't feel like they need to go to the emergency room, but they can ask some questions before and better understand what the resources are. Using
telehealth when it's appropriate. Helping patients get access to insurance or different benefits. Even SNAP, food benefits, that sort of thing. And trauma-informed care, so it's not just one question, but you're asking -- you are going five questions deep to really understand what's going on with the patient and how to take care of them. These are the types of things that you don't get paid for, but they make a big difference.

Using informed care. For example, our investment in trying to help better use the health information, connecting with the immunization registry, and everything that's necessary in order to really capitalize on that visit and understand what's going on with the patient regardless of where they access care so that the provider can be comprehensive in that visit. Having labs on site, medication management, using community health workers -- I mean, specialists, even a part of an FTE to go there to the clinic so that they can access there and not have to drive to Lexington or Louisville.
We try and do that also, kind of what we were talking about earlier, to support the workforce and help individuals wanting to go to the area so that we don't have as many as discrepancies as those maps initially showed and where care can be accessed.

Next. Is that it?

So as Ashley and Mike were talking about workforce development is key, health information is key, so we know if the patient got a vaccine at Kroger or if they got it at another clinic, you know, how to better coordinate health information so that the best, the highest value can be delivered. Having a good attitude about primary care, maybe shifting what people think about going to the doctor and addressing healthcare needs before it becomes something that's delivered to them in the emergency room.

And I think that's it. I kind of rushed through it, but we just thought that it was really interesting that while the private claims data shows that there's about
3 percent investment in primary care, the Medicaid information actually shows that it's about exactly the same. So we're not really investing much in primary care, but that -- the costs are coming from something else, and maybe if we invested more in primary care we could avoid some of those costs.

Do you-all have any questions?

MR. CAUDILL: Any questions for Molly?

MS. KEYSER: This is Chris. I do.

MR. CAUDILL: Go ahead, Chris.

MS. KEYSER: Great presentation. Really good information. I guess my question is, so what would you suggest? I mean, if the information shows not enough money is being spent on primary care, then where does that take place, at the state level or what? Your thoughts on that.

MS. LEWIS: A couple things. I think a lot of it has to do with patient engagement and connecting the patients with the right provider, where they will consider it as, you know, a point of kind of the medical home where the patients will want to go to
address issues and feel comfortable, that it's not something that they dread and avoid, but to help them move access to preventative care and just -- and then also how we use the workforce. Their use of community health workers, different types of workers, so that the clinics can support the workforce that's appropriate for all different aspects of care that take care of the whole patient. So I think that the social determinants of health and some of the issues that drive so much of how we utilize healthcare can be addressed with resources outside of the highest level of expertise. So like the physicians, nurses, those -- if we had a more approach that the face-to-face wasn't the -- face-to-face with a high level provider wasn't the ultimate way of payment, that if we had a more comprehensive understanding of what services are being delivered and how patients are encouraged to be engaged. I think that the patient engagement is a key point. And, Chris, you probably know a lot more thoughts on that from being boots on
the ground. But if we can avoid the hospital visits and then we can also encourage the patient, you know, with discharge planning, for example, if the patient leaves the hospital that they kind of are reoriented towards what they need to do to avoid future ones and to reconnect with their primary care doctor. Those are some of the ideas that we have been talking about.

MS. KEYSER: But, Molly, I guess, in overall of spending of dollars for primary care FQs, you know, who receive a grant to be an access point, you know, the -- those, you know, those grant dollars help them to cover the cost of those ancillary positions that you mentioned and everything and so, you know, what -- you know, what would the private practice role be doing in regard to, you know -- I don't think they are motivated to, well, we are going to hire a social worker or a community health worker or, you know, et cetera, et cetera, et cetera. If I can't bill for the service, if I can't get some reimbursement,
because, you know, I'm in it to make money, I guess, you know -- that's my perspective on the private practice setting, you know. And the role of the FQ is to be good stewards of our grant dollars, and we tend to see that as we have to invest in staff and the right resources for our communities and things like that. So, you know, I guess I'm, you know, still trying to look at does it come down to additional reimbursement from, you know, Medicaid if those kind of services that are not reimbursable now become reimbursable, question mark?

MS. LEWIS: I'll ask Dr. Houghland because he might have some perspective. Do you want to share your thoughts?

DR. HOUGHLAND: I think there's several layers in your questions, Chris, and comments. I think the FQHCs sit in a really special place in the care delivery system in Kentucky, in particular, but just in general they do. And, yes, there are differences between how primary private practices behave than the traditional
safety net. And then there's also differences between those that are independent or multi-specialty practices that are not attached to hospital systems and their behaviors. So, you know, understanding each of those is important. When you look at primary care in general, outside of the safety net, there's a lot more complexity for them to be able to deliver some of those additional services that we do know make a big difference in health.

Now, as the world is shifting away from a transactional fee-for-service, code-based reimbursement model to a combination of that and an incentive model that includes performance and quality and value, it is then brought back to the providers -- it starts changing a little bit. And, you know, really looking at how you are using the total workforce in delivering healthcare and delivering health becomes a lot more viable for many groups, but it really still is targeting the larger groups than the smaller ones, and so there's
still a niche that I think they need some help with. But those value-based contracts I think will over time help deliver value to a broader group or demonstrate value from a broader group than the safety net providers, and that's part of what we are working on with that niche. Other parts of the country have seen some real success in the private world through value-based contracts as well, and so we have to work on getting there.

MR. CAUDILL: Okay. Let me step in. This is really interesting and very timely information; however, if we are going to get you out of here by 12:00 today, we are going to have to move on. We still have a lot of agenda there, so I apologize about cutting this short. Be glad to take it up further discussion of it in the next meeting.

But at this time I'm going to go to new business, 5C, MCO Missed Appointment Information. On my notes it shows that Yvonne Agan and Veronica Cecil will be commenting, and in the chat box I saw that Kristan Mowder with Humana will have some
information on this, too. So, Yvonne, would you like to start out this?

MS. AGAN: Sure. I think this is -- in the context of what we just talked about.

Back in March there were some missed appointment reports that were sent out and it just spurred conversation about various clinics about what is this data, what is it used for, how is the data being captured at the Medicaid level, and is it important for the clinics to know this information and should that be used, reporting the missed appointments. So I'd just like the perspective from DMS on this topic so that we can get information back out.

MS. JUDY-CECIL: So the reason we created the missed appointment reporting is actually through several discussions with MAC and TACs about just, you know, feeling the need to make sure that there's a way to track that. We cannot reimburse, we are prohibited from reimbursing for a missed appointment, but what we agreed with is that what it could do is help identify an opportunity to do outreach to somebody, you
know, is it transportation or child care, and to try to see if there could be some assistance provided to that person. So the information does get sent to the MCOs and at the MAC, the MCOs have been reporting on this and so certainly I know time is limited, Mike, but I think what we had hoped is that the MCOs would have the opportunity to talk about how they are utilizing the information, and if we don't have time today, then maybe we could put it on a future agenda.

MS. AGAN: I think we can move it to a future agenda if we have other topics we need to move on to.

MR. MULLINS: Yes. I'd like to ask one question of Veronica. Does the MCO information include missed dental appointments?

MS. JUDY-CECIL: It does. Yeah, it sure does.

MR. MULLINS: Okay, thank you.

MS. KEYSER: This is Chris. Just another quick question. How do they know there's been a missed appointment?
MS. JUDY-CECIL: So it has to be reported by the provider.

MS. KEYSER: Okay.

MS. JUDY-CECIL: Yeah, that's the tool that we're utilizing to help drive that outreach.

MS. AGAN: Veronica, am I correct in saying that you have to log on to KentuckyHealthNet to report that?

MS. JUDY-CECIL: That's correct, and I understand it's an administrative burden, but it's the only way to capture it. We have -- we have some prolific providers who are doing a really good job of reporting it every time, but, you know, it's sporadic. And the other thing we try to capture from that is what the -- if the member reported, you know -- or if the provider is able to obtain the reason, certainly we try to capture that. I know a lot of times you-all don't know because they just don't show up. But, again, we think it is a great tool to help generate some outreach. And it's certainly is absolutely not about, you know, sigma or, you know, to have any
kind of negative impact to a member, because it doesn't affect the member, except that perhaps we can help -- you know, the MCOs can help try to figure out why the person isn't making new appointments, especially if we have evidence to show that they are not regularly meeting them.

MR. CAUDILL: Kristan Mowder from Humana, did you have something you were wanting to say on this? Going, going -- oh, there you go.

MS. MOWDER: Can you hear me now?

MR. CAUDILL: Yes.

MS. MOWDER: I was going to do one of the presentations like Veronica mentioned, so we can just wait until whenever you put on the next agenda.

MS. JUDY-CECIL: Unless you want them to do go ahead and do a short one. It's up to you.

MR. CAUDILL: What is your pleasure Kristan?

MS. MOWDER: It's up to you guys. It sounds like you have a lot of other items
to go through.

MR. CAUDILL: All right. Let's just bring this back up then at the next meeting. Is that all right then?

MS. MOWDER: That's fine.

MR. CAUDILL: Okay. So let's go on to New Business 5D, Reconciliation, and this is the old part of dealing with reconciliation on the WRAP. For some reason they got mine and your name, Veronica. I wonder why. But ladies first.

MS. JUDY-CECIL: Oh, thank you.

And, actually, perhaps this will be moved up to Old Business, but I appreciate, you know, the interest in it and wanting to have a conversation. You know, one of the reasons for the creation of the workgroup was to -- was out of, I think, the request to do a reconciliation and one that goes back numerous years. The Department did one, and my memory is failing me, many years ago and so I think, you know, there has been interest from providers in trying to do another one. The workgroup and sort of my, I guess, goal has been to make sure that,
you know, there are reasons why there's -- I think everyone feels the need to have one and that's because of, you know, the WRAPs not paying accurately or not generating a WRAP.

And so the workgroup has been really focused on correcting the systems, finding root causes, addressing those because there are three buckets. There's how the provider submits the claim, it's how the MCO processes and submits the encounter, and then it's how our system generates the WRAP. So as you can imagine when you have that complex of a process that something's going to go wrong. And so it's really been the focus to try to correct a lot of that, to identify where the issues are, and develop solutions for them so that we can feel a little more confident in the process working like it should. A reconciliation -- one thing that's clear is that we can only pay a WRAP on an encounter so that we have evidence of the service being rendered and paid, and then to calculate the WRAP appropriately. So, you know, the discussion
of a reconciliation is I think still a little premature. As we work through those system issues, process issues, I really feel like, you know, we need to -- we still have some work to do. Development of the reports, giving transparency to both providers and the MCOs, I think is critically important because that way everybody has the information and is able to walk through it and have discussions and on a provider level try to resolve whatever particular issue is, because it will be very provider specific. So I think that's where we are. It is absolutely our intention to provide guidance, again, you know, and the changes that we're making related to WRAP payments and then at some point -- you know, I think, again, when we feel like pretty confident that things are working as best as they can -- you know, nothing's going to get 100 percent, but, you know, I think at that point then certainly providers and MCOs could discuss how to resolve any of those issues for claims that might not have generated a WRAP.
MR. CAUDILL: At the last meeting we decided to split that. We discussed with you about developing a framework for reconciliation, and I'm hearing that that's still something that you-all are working on. Is that fair?


MR. CAUDILL: Okay. All right. So let's leave that on the agenda for next time.

There was particular questions that were placed on the agenda under Reconciliation. Run through those.

1. Will they allow providers to submit claims back to 2011 with the inception of the new reports since there has already been a reconciliation on that period?

Would you like to address that, please.

MS. JUDY-CECIL: Yeah, I don't -- honestly, because I think there's going to be a lot that goes into what that process is going to look like, I don't think I can address the questions. I just don't have answers for them right now.
MR. CAUDILL: All right. Well, the other one was -- I think, 2 there is, Who is the contact person the providers should contact for reconciliation at DMS after they have run reports and went through MCO?

Do you have a particular person responsible for this?

MS. JUDY-CECIL: No. Again, I think that will -- once we figure out the process, all that information will be provided.

MR. CAUDILL: Okay. And the same thing then about DMS. Has DMS developed the format to submit data?

MS. JUDY-CECIL: Right. It's not developed yet.

MR. CAUDILL: Okay. And let me say that in the workgroup the way that you-all are tracking the issues and the responses is very comprehensive and excellent, I think.

MS. JUDY-CECIL: Thank you for that. I appreciate it.

MR. CAUDILL: Going to New Business, 5E, Reimbursement for Physical Therapy, Occupational Therapy, and Speech Therapy for FQHCs and RHCs. Yvonne is listed.
Would you like to speak to that?

MS. AGAN: Sorry, I was muted.

This is a topic that came up a few months back and I had Molly reached out to you. So we were trying to find any of the regulations regarding the use of physical therapy, occupational therapy, or speech therapy in an FQHC setting. There seems to be a void of any public guidance on this. We did find under KAR 054 and 1055, that provider types, the physical therapists and occupational therapists were to be -- to Provider type 31. It doesn't make any mention to speech therapy. But in the communication that you were helping me with you were able to provide codes back to me that you felt were -- or you felt were eligible for CPS and you were able to send back some PT codes and speech therapy codes.

So I guess the question is can we clean this up, can we go back and look at this and have better publications on the use of these types of therapy in our RHCs and FQHCs? Seems to be a little void of information and it doesn't quite follow
through in a typical format that we are used to working with.

MS. JUDY-CECIL: Based on the question, Yvonne, this is one of those situations where the question seems easy and so that makes me nervous. As we dove into it with our -- with Myers and Stauffer and internally, we were trying to figure out, you know, where -- I guess kind of what generated the question in terms of had you tried to bill for something and it got denied, or you were just really wanting to make sure that you're in compliance with the ability to bill for those services. As far as we know, and certainly, you know, we could try to provide something in writing, this -- you know, physical therapy, occupational therapy and speech therapy should be services that are provided by an FQHC and RHC. So I don't know, Lee, if you have any -- I'm going to put you on the spot. But, Lee Guice, I don't know if you have any other thoughts on that as we kind of discussed it.

MS. AGAN: I think it comes from the
situation if you're considering can you expand into these services, you're trying to make -- have assurance that it is a reimbursable service, and when it's not clearly in writing and left up to interpretations, just trying to clarify it.

MS. GUICE: So at a high level it is a reimbursable service. I want to make sure, since you brought up the phrase, change in scope of service, we are not answering that question now because --

MS. AGAN: That -- (Crosstalk)

MS. GUICE: Okay, good. I just want to make sure. But, yes, just from -- you know, you have to make sure that you follow all the licensure requirements and then you're fine.

MR. CAUDILL: What is high level, Lee?

MS. GUICE: At a high level?

MR. CAUDILL: When you say reimbursable at a high level, what is high level?

MS. GUICE: I'm sorry, I meant from a 30,000-foot view and not getting into the weeds of is it a change in scope of service, you know, per the reimbursement,
the PPS regulations. So that's what I was trying to say about at a high level. Not at a higher rate or any of that. I just meant from a 30,000-foot view.

MR. CAUDILL: All right. And my understanding it's not reimbursable either, so we definitely need to have a clearer understanding of what is and isn't in regards to those, at least from my standpoint.

MS. AGAN: Any other questions on that?

MR. CAUDILL: All right. Any questions or other comments on that subject?

Then let's go down to New Business, 5F, Changes to Telehealth upon expiration of Public Health Emergency. Teresa Cooper, are you wanting to address this?

MS. COOPER: Mike, the TAC had asked for an explanation from Medicaid of what they foresaw, if any, changes happening to telehealth when the public health emergency expired. So I will defer to Lee or Veronica for that.

MR. CAUDILL: Okay. So I thought, Veronica, we were leaving you out of one,
but I guess not.

MS. JUDY-CECIL: So honored. So right
now -- I will have to say we filed a
telehealth regulation and incorporated into
that is a lot of the flexibilities that we
expanded under the public health emergency.
We are required to defer to the Office of
Civil Rights on the platforms and the
ultimate requirements around telehealth and
the State Medicaid Agency. I think the
only -- probably of most concern is going
to be the platform that can be used. You
know, right now you can use FaceTime and
other platforms such as that, which is part
of the flexibility that's allowed under the
PHE, PHENs, that those type of platforms
will not be allowed. But in terms of the
services that can be delivered and who can
deliver those services, what our telehealth
regulation makes clear that as long as the
licensing board and professional standards
and the correct coding guidelines permit
that service to be delivered through
telehealth, then Medicaid would cover it
that way. Does that help?
MR. CAUDILL: I know that in my area, rural southeastern Kentucky, communications is a real problem, and there's still many areas that do not have internet service or do not have sufficient strength to be able to do a face-to-face. And the ability of especially among our older people to be able to use the telephone because it's an approved cost is very important. I think it would make a negative substantial difference if that goes away. That's just my comment and it goes under the for-what-it's-worth category.

Anyone else like to have a comment or ask a question concerning this?

MS. AGAN: I would agree with Mike, saying I think if we limit the platforms, it will limit care to some patients that might otherwise not have that access. I want to make sure that we are considering those options.

MS. JUDY-CECIL: I will say that I think we are implementing -- that increases it to the best of our ability. We don't control ultimately what the, you know, platforms
that are allowed to be used. But I do believe we are leveraging and taking advantage of everyone that we can.

MR. CAUDILL: Let me ask this question. It's hard to separate out because of the umbrella that Covid has affected this in every walk of life, especially in healthcare. But these relaxed rules about telehealth have they caused much of a difference in how much it costs the Department to provide this care through its Medicaid recipients?

MS. JUDY-CECIL: We have pulled data about the service expenditures of services, both, through in person and telehealth prior to the public health emergency and then since. And, you know, I think what we have seen is that, which is a good thing, is that expenditures have kind of, or services have kind of returned to normal with the use of telehealth. Where you see the decrease in in-person services, you have seen an increase in the telehealth. So that to us at least demonstrates that, you know, that access to the extent that, you know, it's
possible is there and available. We understand that there are some shortcomings to that, but people are utilizing services through telehealth.

MR. CAUDILL: Okay. Any other questions?

Let's move on to New Business 5H, which is MCO Covid-19 Member Incentives and Reference Guide. And also under that we will take up the individual reports of the MCOs. But start with on the incentive reference guide, and looking over it and I think part of the reason that DMS wanted to bring this forward is the fact that the incentives as listed have expired or will expire in very near future. So maybe as we go through this, the MCOs can update us as to what their particular MCO is doing, have these benefits sun-setted or have they been renewed with other future expirations set or what.

MS. CLARK: Mike, this is Angie Clark with Medicaid. Just as an aside to that, or part of this, I did ask all of the MCOs earlier in the week or last, seeing this on the agenda, to update this guide, but
obviously they can let you know. And we should have all of that updated by tomorrow and submitted out so that everybody will have an updated document on any changes that they are looking to provide.

MR. CAUDILL: That will be great. That will be great.

So let's start then with Humana. Beth Day you were speaking last time we met. Are you representing Humana today or someone else going to speak up.

MS. DAY: Dr. Caudill, this is Beth Day. I did want to let you guys know that we do not have any set expiration forthcoming for the Covid incentive program that we have available. We do offer all of our Medicaid members the opportunity to take advantage of the Go365 Program, that they do accrue rewards for any kind of healthy behaviors that they make. They can connect fitness trackers with their phone in order to track their steps, and they get rewards for that, along with other healthy activities such as getting their immunizations, taking care of any kind of wellness alerts that they get.
We do have that available to them.

    Did you want me to go ahead and give
any other updates as well during this?
MR. CAUDILL: Yes, please do.
MS. DAY: Okay. I did just want to give a
little reminder to our physician groups
that we do have a tool available on
Availity for questions or disputes about
any kind of financial recoveries that would
come out, or any kind of overpayment alerts
that you do receive. It's a wonderful tool
and actually cuts out you having to go
through customer service for any questions.
It actually sends your questions directly
to our payment integrity team. You can
review the remit around that. You can ask
any questions that you have around the
reasoning behind that, or any kind of
regulations that we're applying around
those recoveries or overpayments that we
are alerting you to, and it actually just
has a chat feature where you are actually
going to be chatting directly with that
team. So you are going to get a lot better
feedback and a more intelligent answer, I
think, than if you were to reach out
directly to me or customer service. So
just wanted to remind everybody that that
is available to you. It's a wonderful
tool. I think expedites the process for
you, and certainly if you have a dispute
that is definitely something that we would
need to overturn for you, it's going to
make that faster for you, too, and avert
any kind of recoveries for you guys that
would be overturned. So just a reminder
that that's out there through the Availility
tool. It's a wonderful thing.

Outside of that, we don't really have
any changes to our processes. We are still
in effect with all of our current Covid
practices and the allowances around that.
And just happy to have you guys out there
with your boots to the ground continuing
with the efforts around making sure
everybody's immunized and doing what we can
to get things back to normal.
MR. CAUDILL: Okay, thank you.

Next up will be Wellcare. Johnny
Akers last time. Johnny, are you on today?
Is anybody else on for Wellcare? All right, no report for Wellcare today.

Next we go to Aetna. Becky Marcums last time. And, Becky, let me say that was an excellent report you gave last time. You-all have a lot going on. Not to give you any pressure about how good you have to do today or anything.

MS. MARCUMS: Can you hear me?

MR. CAUDILL: Yes.

MS. MARCUMS: Background noise. Can you hear me now.

MR. CAUDILL: Yes, you're fine.

MS. MARCUMS: Thank you, Mike. I appreciate that.

Our vaccine incentives are going to end June 30th, 2022. So it's coming up, but it will end for Aetna members and providers.

MR. CAUDILL: Okay.

MS. MARCUMS: And then our update is for -- it started May 1st, 2022, under the guidance of Commonwealth of Kentucky of -- our PAs are going to start going back into effect. So Aetna Better Health of Kentucky will require a PA for provider type 93,
provider types 12, and also they will require a PA for outpatient service, procedures at other outpatient facilities or other Medicaid services based on their utilization management program, except for individuals with a Covid diagnosis. A PA will remain in place for all pharmacy benefits and products listed on the Physician Administrative Drug List.

To facilitate provider payment requirements for preauthorization of non-Kentucky Medicaid enrolled providers will remain in place. And PA for Medicaid coverage substance abuse and behavioral health services continues to be waived. And that's all we have.

MR. CAUDILL: Okay. All right. Thank you, Becky.

Next would be Shelley Fife with Molina. And, Shelley, Molina is one of the three that services have already expired.

MS. FIFE: Actually, they go through June 30th. We extended that. And that is also subject to change depending on where we are at with our numbers. Our incentives
can still be claimed by anyone who is eligible to receive the booster as defined by CDC, and they must have Passport by Molina as primary coverage, and it just kind of goes down the line from there, and only one reward a member can be claimed. I can send those notes over to you, Mike, just...

MR. CAUDILL: That was one reason why we wanted to update this, that we have, because it shows under this that the incentives are offered through March 31st.

DR. JAMES: This is Dr. Tom James. I'm chief medical officer. I want to give you an update that is maybe a half-hour old. Our president, Ryan Sadler, and I, we have -- we will continue the benefit and review on a regular basis, but he's expecting it to go to October, because we want to be prepared for a fall uptick in Covid.

MR. CAUDILL: That's great. Thank you.

DR. JAMES: I'll get to that to you in writing, so you guys --

MS. FIFE: Also, thank you so much for sharing that.
MR. CAUDILL: Kelly, would you like to go ahead then with your update?

MS. FIFE: I can. So we have introduced our Care Connections Program this last fall. The goal of the program is to meet Kentucky members where they live and work, offering home visits, mobile clinics, community-based pop-up clinics and telehealth virtual visits. The purpose of our team is coordinate care and facilitate communications between members, their primary care physicians, and care management. This team is also responsible for accurate and comprehensive documentation of member diagnoses, as well as addressing gaps in care. We are not trying to take anything away or no claims are going to be filed from these meetings. It's more or less just trying to help members get to their appointments, make sure that they are being taken care of, making sure that they are seeing the specialists that they need to see, and medications that they need to take.

MR. CAUDILL: Okay. Thank you.
MS. FIFE: Thank you.

MR. CAUDILL: And last would be United, which is also one that shows that their incentives have been expired through December 31st of last year. So maybe you can update us on that. That is Dr. Cantor.

DR. CANTOR: Yes, hi there. Thank you.

Actually, our incentives for Covid-19 vaccinations with co-vaccination is extended through the year end of 2022, December 31st of this year, and it's $100 gift card to be fully vaccinated. It does not include the boosters. The goal is to still promote that. We also have Mom's Meals for 14 meals if you get fully vaccinated with the Covid vaccine through the end of Q2. That gift card that I was mentioning, the $100 gift card, that's for anybody ages five years and older if they have United Healthcare. And that's our update for the Covid vaccines.

In terms of other updates from UHC, just a reminder to our providers that to be able to check the network news on the provider portal for any codes that might be changed to the prior auth list, and what
recently came up is something like the hyaluronic acid injections. That has been added to the PA list, and E-stim. So perhaps not always to the primary care physician, but general reminder that those updates are made on the provider portal. Thank you.

MR. CAUDILL: Okay, thank you.

Stuart Cox, were you wanting to update on Anthem?

MR. COX: Yes, sir. We do have an Anthem update on the Covid vaccination. We are prepared, at least through December 31st, 2022, to continue the member vaccination incentive and the provider incentive and will continue to monitor and accept feedback, look forward to feedback from the TAC on that as well, but we are definitely planning to sustain through 2022.

MR. CAUDILL: All right. Did Anthem have an update? Looks like I've missed calling on you-all.

MS. BUCHANAN: Yes, this is Rachel. I provided the update. Thank you, Stuart.

MR. CAUDILL: Okay, thank you, and thank
you, Stuart.

MS. BUCHANAN: Hi, this is Rachel Buchanan with Anthem. I do have one announcement that I'd like to share. This is about our Tobacco Cessation Program. Anthem's working with the EX, that's E-X, Program by Truth Initiative, which is a digital platform dealt in collaboration with the Mayo Clinic, to assist patients in quitting tobacco use. The program offers such resources of personalized quit plan, social support from an online community, coaching from tobacco treatment experts via live chat, and nicotine patches, gum, or lozenges delivered to the member's home. This tool can be accessed from a smart phone, tablet, PC, and it's offered at no cost to our members. There's also communication and a flier posted to our Anthem website about this. And that is all I have today.

MR. CAUDILL: Thank you so much. That ends the updates from the MCOs.

At this time let me revisit the recommendations to the MAC, and we talked
about the situation with dental. Do you have specific wording that you would like to do on that, Raynor?

MR. MULLINS: Yes, I have been working on that while I was listening to the other reports. I'd like to recommend that we can ask the MAC to support the recommendation from the Primary Care TAC to the Cabinet, and Office of Policy for review of current dental workforce shortages including the use of dental auxiliaries to expand capacity in Kentucky. That's the first part of the recommendation.

MR. CAUDILL: Okay.

MR. MULLINS: And then I'd like the TAC to recommend a review by the Cabinet and the Office of Policy of the current workforce situation and I'd like to ask the MAC to support that.

MR. CAUDILL: All right. Comments from the committee members? Can we get a motion on whether we want to make that recommendation?

MR. MULLINS: I move that we recommend that.
MR. CAUDILL: Motion made. Is there a second?

MS. KEYSER: This is Chris. I'll make the second.

MR. CAUDILL: Chris has made the second. All those in favor of the recommendation to the MAC as read by Raynor Mullins, please say aye.

(Members voted affirmatively.)

MR. CAUDILL: All those opposed?

(No response.)

MR. CAUDILL: All right. Motion carried. We will make that recommendation to the MAC.

MR. MULLINS: Mike, I'd like to make a second recommendation.

MR. CAUDILL: All right.

MR. MULLINS: That the Primary Care TAC recommend this policy review should include, one, current dental enrollment levels in state dental colleges; two, equity in dental reimbursement in state Medicaid and managed care programs; and three integration of dental services at the public health departments, hospitals,
school health, primary care, and rural health clinics. In other words, I think we should ask for a comprehensive look at this that includes dental enrollment, dental reimbursement, and the integration of dentistry in appropriate settings. That's in the spirit of what we talked about.

MR. CAUDILL: Right. Should they be looking at revisiting the policy of how many out-of-state slots would be available?

MR. MULLINS: Well, I think if you get into looking at enrollment levels, that's what that includes, Mike.

MR. CAUDILL: Okay.

MR. MULLINS: It's not only that. It's the total enrollment numbers, it's the out-of-state, in-state mix, it's the applicants from rural counties proportion, pipeline -- pipeline issues, those things.

MR. CAUDILL: Would you like to go ahead and make that in the form of a motion to approve that to be presented to the MAC as you read it, Raynor?

MR. MULLINS: Okay.

MR. CAUDILL: And is there a second?
MR. MULLINS: Well, you want me to read it to be a little more specific? I realize, it's a little long, but I think it's complete.

MR. CAUDILL: Well, and I'm going to have KPCA to write it up and then circulate it among us and make sure that we are all okay with it.

MR. MULLINS: That would be fine. I'm happy to try to send it along, the draft. I move that the Primary Care TAC recommend a dental policy review that should include current state dental enrollment -- I'm sorry -- current dental enrollment levels in state dental colleges and loan forgiveness options for dental graduates; two, equity of dental reimbursement in state medicaid and managed care programs; three, the integration of dental services in public health departments, hospitals, school health, primary care organizations and rural health clinics.

MR. CAUDILL: And that's in the form of a motion; right?

MR. MULLINS: Yes.
MR. CAUDILL: Okay. Is there a second to that motion?

MS. KEYSER: This is Chris. I'll make that second again.

MR. CAUDILL: All right. Motion made and seconded concerning the recommendation to the MAC. All those in favor say aye?

(Members vote affirmatively.)

MR. CAUDILL: All those opposed, same sign.

(No response.)

MR. CAUDILL: Motion carries.

That moves down to New Business, No. 6, Confirmation of Chair to attend MAC Meeting, May 26, and I will be attending that meeting. And the next meeting is Item No. 7, is set for Thursday, July 7th at 10:00 a.m. to 12:00 p.m.

And that is all that I have on here and I've held you over a few minutes. Do we have a motion to adjourn?

MS. KEYSER: This is Chris. I'll make the motion.

MR. MULLINS: I'll second. And, Mike, I'll send along some draft of this to be more precise on it.
MR. CAUDILL: Okay, that will be great. We put you here over a few minutes, so I apologize for that.

Motion made by Chris and seconded by Raynor to adjourn. All those in favor, aye. (Members vote affirmatively.)

MR. CAUDILL: Okay. Thank you—all for being with us and sorry about getting a little bit of a late start there.

Have a wonderful day and God bless you.

* * * * * *

THEREUPON, the Meeting was concluded at 12:04 p.m.

* * * * * *
STATE OF KENTUCKY    
COUNTY OF FAYETTE    

I, JOLINDA S. TODD, Registered Professional Reporter and Notary Public in and for the State of Kentucky at Large, certify that this transcript is a true and accurate record of the Primary Care TAC meeting held on May 5, 2022.


IN TESTIMONY WHEREOF, I have hereunto set my hand and seal of office on this the 29th day of June 2022.

JOLINDA S. TODD, RPR, CCR(KY)
NOTARY PUBLIC, STATE AT LARGE
carved [1] 23/7
cash [1] 34/13
cash-basis [1] 34/13
categories [1] 18/25
category [1] 69/13
Caudill [3] 2/6 3/12 72/12
cause [2] 19/25 20/5
caused [1] 70/9
causes [1] 60/8
CCR [1] 88/18
CDC [1] 77/3
center [1] 31/21
centered [1] 37/24
centers [7] 19/3 25/3 38/15 38/16 41/23 46/1 46/21
 certainly [10] 8/1 9/8 9/10 14/18 56/6 57/19 57/24 61/22 65/15 74/6
certify [1] 88/10
Cessation [1] 81/5
cetera [4] 33/11 51/23 51/23 51/24
chair [2] 33/14 86/13
Chairman [1] 2/6
change [6] 22/21 43/16 46/8 66/9 66/24 76/24
changed [3] 30/1 34/9 79/25
changes [6] 4/1 61/16 67/15 67/20 72/4 74/15
changing [2] 34/17 53/19
chat [5] 17/25 30/4 54/24 73/22 81/14
chatting [1] 73/23
check [1] 79/23
cherrypicking [1] 34/13
chief [1] 77/14
child [1] 56/1
Chris [19] 2/11 3/14 8/3 28/24 28/25 31/8 39/4 49/11 49/12 50/12 50/24 52/19 56/23 83/3 83/5 86/3 86/21 87/4
circulate [1] 85/6
Civil [1] 68/8
claim [1] 60/10
claimed [2] 77/1 77/6
clarify [1] 66/6
Clark [1] 71/21
clean [1] 64/21
clear [3] 33/17 60/21 68/20
clearer [1] 67/7
clearly [1] 65/5
click [2] 38/7 38/7
clenical [2] 29/18 39/7
clenically [1] 39/5
eilities [9] 38/17 46/2 50/7 55/8 55/11 78/7 78/8 84/2 85/22
close [1] 31/5
co [3] 20/14 24/18 79/9
co-located [1] 24/18
co-location [1] 20/14
co-vaccination [1] 79/9
coaching [1] 81/12
code [1] 53/15
code-based [1] 53/15
codes [4] 64/16 64/19 64/19 79/24
coding [1] 68/22
collaboration [1] 81/8

collaboratives [1] 38/10
collective [1] 38/11
colleges [2] 83/21 85/15
combination [1] 53/16
combined [1] 21/21
come [9] 6/13 7/5 7/10 15/16 26/16 30/21 38/23 52/10 73/10
comfortable [2] 46/20 50/1
coming [7] 10/22 26/19 27/16 36/20 37/25 49/5 75/17
comment [4] 14/24 33/18 69/12 69/14
commenting [1] 54/24
comments [5] 15/3 18/19 52/20 67/13 82/20
commercial [1] 33/14
commission [2] 8/15 88/14
Commissioner's [1] 7/22
committee [3] 8/19 10/15 82/21
Committee's [1] 9/7
COMMONWEALTH [2] 1/2 75/22
communicate [1] 9/18
communicating [1] 30/10
communication [2] 64/15 81/19
communications [2] 69/2 78/11
communities [3] 30/12 30/12 52/7
community [9] 19/2 20/13 23/21 38/14 47/21 50/6 51/22 78/8 81/12
community-based [1] 78/8
compared [1] 40/20
compass [1] 43/17
compassionate [1] 46/15
competitive [2] 15/24 17/23
complete [1] 85/4
completely [1] 34/8
complex [1] 60/14
complexity [1] 53/9
compliance [1] 65/13
complications [1] 33/10
compound [1] 21/15
comprehensive [9] 37/24 45/10 46/7 46/16 47/20 50/20 63/19 78/14 84/3
compromise [1] 29/24
conceivably [1] 10/21
concept [1] 45/7
concern [2] 11/10 68/11
concerned [1] 8/20
concerning [3] 18/15 69/15 86/6
certified [1] 24/25
concluded [1] 87/13
confident [2] 60/19 61/19
Confirmation [1] 86/13
connect [1] 72/20
connecting [3] 3/7 47/14 49/22
connection [1] 3/8
Connections [1] 78/4
consider [2] 30/11 49/23
consideration [2] 9/12 33/1
considered [1] 39/20
considering [2] 66/1 69/20
consistency [1] 7/6
consistent [1] 13/11
constraints [1] 10/16
contact [2] 63/3 63/3
contacted [1] 26/11
context [1] 55/4
continue [6] 6/25 14/18 37/6 77/17 80/14
Established [1] 30/19
et [4] 33/11 51/23 51/23 51/24
et cetera [3] 33/11 51/23 51/24
even [4] 17/17 18/17 47/3 47/22
every [4] 31/5 39/23 57/15 70/7
everybody [4] 36/23 61/9 72/3 74/3
everybody's [1] 74/21
everyone [4] 3/24 5/25 60/2 70/3
everything [2] 47/15 51/17
evidence [2] 58/7 60/23
evolve [1] 38/21
EX [1] 81/6
exacerbate [1] 32/8
exact [1] 27/4
exactly [2] 34/22 49/3
examination [1] 19/22
example [4] 44/8 44/15 47/12 51/4
exceeds [1] 29/9
excellent [2] 63/19 75/5
except [2] 58/3 76/5
excuse [1] 6/22
exhaustively [1] 22/16
expand [3] 30/20 66/2 82/11
expanded [1] 68/6
expect [1] 17/7
expectancy [2] 44/5 44/9
expecting [1] 77/18
expedite [1] 94/5
expedites [1] 70/14 70/19
expenses [1] 39/25
expertise [1] 50/15
experts [1] 81/13
expirations [1] 71/19
expire [2] 5/1 71/15
expires [1] 88/14
explanation [1] 67/19
extensive [1] 15/10

feel [8] 18/19 45/3 45/14 46/22 50/1 60/18
61/3 61/18
feeling [2] 44/17 55/19
feels [2] 46/20 60/2
felt [2] 64/17 64/17
few [3] 64/3 86/19 87/2
Fife [1] 76/19
figure [5] 21/11 41/7 58/4 63/9 65/8
figures [1] 29/10
file [1] 13/13
filed [3] 13/15 68/3 78/18
filling [1] 13/24
fill [1] 33/13
finalize [1] 17/10
financial [1] 73/9
find [5] 8/15 11/17 34/10 64/5 64/10
finding [1] 60/7
findings [1] 14/19
fine [4] 59/5 66/17 75/13 85/9
finished [2] 17/7 17/10
finishes [1] 15/6
82/12
firsthand [1] 32/3
fitness [1] 72/20
five [2] 47/7 79/18
flat [1] 41/1
flexibilities [1] 68/5
flexibility [2] 10/3 68/15
flier [1] 81/19
flow [1] 26/22
flying [1] 21/1
focus [1] 60/16
focused [1] 60/7
follow [2] 64/25 66/15
food [1] 47/3
foot [2] 66/23 67/4
force [2] 16/9 18/2
forces [1] 29/22
forecast [1] 11/11
foresaw [1] 67/20
28/13 28/14 85/16
form [2] 84/21 85/23
format [2] 65/13 65/1
forthcoming [1] 72/14
forward [3] 38/11 71/13 80/17
found [1] 24/20
founded [1] 38/13
four [1] 34/5
fourth [1] 19/5
FQ [1] 52/4
FQHC [2] 64/8 65/20
FQHCs [4] 13/8 52/20 63/25 64/24
FQs [2] 27/24 51/13
fraction [1] 24/3
framework [1] 62/3
Frankfort [1] 9/4
front [2] 27/5 46/19
FTE [1] 47/23
full [1] 37/11
fund [1] 24/20
funded [1] 25/12
funds [1] 25/9
further [4] 19/8 20/22 21/15 54/18
future [6] 16/10 51/7 56/12 56/14 71/15