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

IN RE: PRIMARY CARE TAC MEETING

May 6, 2021
10:00 A.M.
(All Participants Appear Via Zoom or Telephonically)

APPEARANCES

Mike Caudill
CHAIRMAN

Yvonne Agan
Chris Keyser
Barry Martin
TAC MEMBER PRESENT

Teresa Cooper
Edward Conners
Mary Elam
David Bolt
John Inman
Molly Lewis
Stephanie Hall
Chuck Morgan
KENTUCKY PRIMARY CARE
ASSOCIATION

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APPEARANCES
(Continued)

Veronica Cecil
Angela Parker
Steve Bechtel
Lee Guice
Amy Richardson
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. Call to Order

2. Establishment of a Quorum

3. Review and approval of previous meeting transcript
   A. March 2021

4. Old Business
   A. Report on Wrap/Cross Over Claims Clean-up July 1, 2014 to present - update from DMS
   B. Payments for COVID-19 Vaccine Administration – update from DMS

5. New Business
   A. Presentation on payment methodology for same day multiple visits
   B. Updates or Announcements from the MCOs
   C. Recommendations to the MAC
   D. Confirmation of Chair to attend MAC meeting – May 27, 2021 – 10:00 AM – 12:30 PM
   E. New items for discussion
   F. Next Meeting – July 1, 2021 – 10:00 AM – 12:30PM

6. Adjournment

1 MR. CAUDILL: I've got 10:01.
2 So, if there's no reason for delaying, I'll go ahead
3 and call this meeting to order.
4 For the purpose of establishing
5 a quorum, I'm here. Chris Keyser, are you here?
6 MS. KEYSER: Present.
7 MR. CAUDILL: Good. Yvonne?
8 MS. AGAN: Present.
9 MR. CAUDILL: Barry?
10 MR. MARTIN: Barely.
11 MR. CAUDILL: Barely Barry is
12 here. Okay. Raynor Mullins? Raynor emailed me last
13 night that he had a medical appointment that he had
14 to take and may or may not be able to join us today.
15 So, he's not here when we're starting, but if
16 everything concludes timely for him, maybe he can
17 join us before this is over.
18 So, that's four out of five.
19 That's a quorum.
20 Would someone like to introduce
21 the Medicaid staff that's in attendance today?
22 MS. CECIL: Good morning, Mike
23 and members of the TAC. This is Veronica Cecil with
24 Medicaid. Sharley is not able to join today even
25 though you see her name. Donna Clark has been

1 grateful enough to help us get started this morning.
2 I am going to try to share my
3 screen for the agenda. We'll see if that works.
4 (INTRODUCTIONS)
5 MR. CAUDILL: Would someone like
6 to identify the members of the Kentucky Primary Care
7 Association that's on?
8 (INTRODUCTIONS)
9 MR. CAUDILL: Thank you. My
10 agenda is misnumbered. So, five becomes four and six
11 becomes five and seven becomes six to make it in line
12 with how I was taught my numbers go anyway. Four is
13 missing on that.
14 Having said that, then, it is
15 time to address Old Business, and the first order on
16 that is a report on the wrap/crossover claims of July
17 1, 2014 to the present, and we're asking for an
18 update from DMS on that.
19 MS. KEYSER: Mike, this is
20 Chris. I'm sorry. Do we need to approve the minutes
21 from the previous meeting?
22 MR. CAUDILL: You know? We do
23 and that's my bad. So, let me step back, then, and
24 ask if there's any changes or modifications to be
25 discussed to the meeting transcript of 3/4 of '21?

1 If there's not, the Chair will
2 entertain a motion to approve those as distributed.
3 MS. KEYSER: So moved. This is
4 Chris.
5 MR. CAUDILL: Thank you, Chris.
6 Is there a second to that?
7 MS. AGAN: Yes. This is Yvonne.
8 I will second.
9 MR. CAUDILL: Thank you, Yvonne.
10 All those in favor say aye. All those opposed say
11 likewise. The motion to approve the previous meeting
12 transcript passes.
13 Now let us go to Old Business
14 under A and, Veronica, will you be addressing that?
15 MS. CECIL: Yes, sir. So, we
16 did have the first wrap workgroup, well-attended. It
17 was Managed Care Organizations, our providers,
18 members from the Primary Care TAC, from the Kentucky
19 Primary Care Association, obviously Department staff,
20 and staff from the Office of Application Technology
21 Services (OATS), our IT sister agency.
22 I thought it went very well.
23 It was very informative. We asked for feedback from
24 that meeting and we did receive feedback from nine
25 organizations. So, we are taking that back and going

1 through that information.

2 We’re trying to schedule the

3 second workgroup meeting and just I’m having a little

4 difficulty in aligning some of the key participants

5 to make sure that we’ve got the technical people on

6 and providers represented.

7 So, I hope to get the invite

8 out to that today because I do have to reach out to

9 some individuals and ask them if they could be

10 available for different days that they did not

11 indicate.

12 So, hopefully, that invitation

13 will go out. That meeting will happen in two weeks.

14 And as part of that agenda, we will be hearing from

15 the provider side about Medicare billing.

16 I think that will be very

17 helpful to the Department to understand that side of

18 it from the provider perspective. So, we appreciate

19 the willingness for that kind of presentation.

20 So, that’s where we are right

21 now on resolution of the wrap. Any questions?

22 MR. CAUDILL: So, the issues

23 that were discussed in the workgroup meeting, do

24 those correspond with the issues that you referred to

25 at our last meeting of this committee as needing to

1 be addressed?

2 MS. CECIL: Yes. And we do plan

3 at the next workgroup meeting to dive in a little

4 further based on the feedback from the different

5 stakeholders to help us.

6 Again, the goal of this is to

7 develop resolutions to the problems that affect the

8 generation of an accurate and timely wrap. And,

9 then, what do we do about going backwards to try to

10 ensure that providers were paid appropriately?

11 MS. KEYSER: Mike, this is

12 Chris. I've got a question.

13 MR. CAUDILL: Yes, Chris.

14 MS. KEYSER: It's for Veronica.

15 Veronica, are there minutes kept of the workgroup

16 session?

17 MS. CECIL: We do not keep

18 specific minutes.

19 MS. KEYSER: Is there like an

20 agenda or something that can be shared so this

21 committee has an idea as far as what topics were

22 covered?

23 MS. CECIL: Oh, absolutely. I'd

24 be happy to share that.

25 MS. KEYSER: Okay. That would

1 be great. Thank you.

2 MS. CECIL: And I'm happy to

3 share the Powerpoint presentation that was presented.

4 So, yes, absolutely, we're happy to share that

5 information.

6 MS. KEYSER: That would be

7 great. Thank you. You can send it to Teresa.

8 MS. CECIL: What I'll do is

9 we'll send it out to the TAC members. And, then, if

10 anybody else would like to have it, just reach out to

11 Sharley and we'll get that to you.

12 MS. KEYSER: Thank you.

13 MR. CAUDILL: Let me ask you.

14 Would it be possible to go one step further and do a

15 summation of the main points out of that meeting?

16 MS. CECIL: Yes, we can do that.

17 MR. CAUDILL: That would be

18 great for me.

19 MS. AGAN: Veronica, this is

20 Yvonne. Did you say when the next workgroup session

21 is going to be or did I not hear that correctly?

22 MS. CECIL: I'm hoping to

23 finalize that date today. Like I said, I had to

24 reach out to a couple of individuals directly that

25 didn't indicate the day that almost everybody else

1 was available. So, once I get all that confirmation
2 back, I hope to get that out today.
3 MS. AGAN: Okay, but you haven't
4 chosen a date yet.
5 MS. CECIL: No. I think we're
6 looking at May 17th.
7 MR. CAUDILL: Any other
8 questions on that for Ms. Cecil?
9 As part of the last meeting, we
10 also talked about some reports that were being done
11 and you had identified there were two reports being
12 worked on that there had been a back-and-forth report
13 as to what had been paid, what wraps had been paid so
14 that a reconciliation could occur more realtime and a
15 separate report that the providers could utilize as
16 part of their reconciliation.
17 Has there been any progress in
18 those areas?
19 MS. CECIL: They're not
20 finalized yet but I think we're pretty close,
21 definitely on the one to be utilized by the Managed
22 Care Organizations.
23 And, again, the purpose of that
24 is for them to be more proactive in reviewing claims
25 they've paid and there's no wrap that's been

1 generated so that they can go back and review those
2 and work with providers in case it's a problem from
3 that side.
4 MR. CAUDILL: So, it won't
5 aggravate you if we put that on the agenda for the
6 next meeting for a status on that?
7 MS. CECIL: Oh, no. I'm happy
8 to do that.
9 MR. CAUDILL: Okay. You and I
10 have corresponded a little bit during this interim
11 about a work flow chart.
12 MS. CECIL: Yes.
13 MR. CAUDILL: Is that something
14 that is going to be able to happen?
15 MS. CECIL: Yes. And I think I
16 failed to mention one of the key players in this was
17 Gainwell and they were certainly at the meeting, and
18 they did take that back and they are working on it.
19 They said it would take about three weeks. So, we're
20 right about the time that they might be able to have
21 that available for us.
22 MR. CAUDILL: Okay. Great.
23 Wonderful. Thank you. Any other questions for
24 Veronica or DMS concerning A?
25 MS. AGAN: I'd like to ask

1 Veronica a question.
2 So, one of the things that we
3 are currently experiencing is the recent fee schedule
4 adjustments that occurred by one of the MCOs. And
5 when they did their fee schedule adjustments and sent
6 those encounters over, the typical thing happened.
7 DMS did a complete void of the wrap and recouped all
8 the money and those claims have never gone back
9 through even though it's been months.
10 So, when you're working on
11 these reports that you're going to send people, we're
12 still sitting here right now with absolutely no
13 direction on current serious problems like that. It
14 holds a lot of money on the table, and the
15 recommendations are do we reach back out to the MCOs
16 or do you go with that?
17 So, I think that's part of the
18 workgroup agenda and I just want to make sure that we
19 keep that front and center because that's still a
20 very serious problem.
21 MS. CECIL: Can you send that to
22 me in an email so that I can make sure that it's on
23 our radar?
24 MS. AGAN: Sure. I can give you
25 (inaudible) numbers, too, if you want them.

1 MS. CECIL: That would be
2 fantastic.
3 MR. CAUDILL: All right. Any
4 other questions or comments?
5 Then, let's move to Item 4B,
6 payments for COVID-19 vaccination administration -
7 update from DMS.
8 This surprisingly was a really
9 good conversation we had last time and it took up a
10 lot of pages on the transcript. I know the
11 Department has resolved most of these issues, but
12 would someone care to summarize that on behalf of the
13 Department?
14 Veronica, you're nodding. Will
15 that be you?
16 MS. CECIL: I think so. I don't
17 know if Lee Guice has anything to add, but I'm glad
18 that you have this on here because what we wanted to
19 double check is to see are providers having any
20 issues with billing that vaccine.
21 The resolution to the back and
22 forth was that we were going to treat the COVID
23 vaccination administration similar to other vaccines.
24 And, so, you would get the administration fee
25 directly.

1 We did go back and check our
2 system to make sure that it could be billed
3 appropriately fee-for-service side; and as far as we
4 know, I've not heard any issues from that. So, I
5 certainly would like to know if that seems to be
6 going through okay.
7 MR. CAUDILL: Do any of the
8 providers have any comments or experiences to share
9 with Veronica concerning that?
10 MS. AGAN: I don't think I can
11 give an update on that today.
12 MS. CECIL: Well, definitely do
13 reach out fee-for-service or MCO side. This is
14 important to us. We want to make sure. We
15 appreciate what you all are doing to get our
16 population vaccinated. And, so, if there are any
17 challenges to that, please let us know.
18 MR. CAUDILL: From our
19 standpoint, the solutions that the Cabinet came up
20 with has worked well for us and we're happy with it
21 and not having any problems.
22 At this point in time, we've
23 given out 11,549 doses since we began and it's
24 working well.
25 Maybe on subject, maybe off

1 subject a little bit - perhaps under New Items for
2 Discussion, we'll discuss more of the actual
3 mechanics of how that's going and what trends we're
4 seeing in the COVID distribution. So, I'll wait
5 until that time.
6 MS. CECIL: I will add that
7 Secretary Friedlander is very interested in
8 increasing the population that's vaccinated. And,
9 so, we have been talking with the MCOs about what
10 kind of incentives, whether a provider or member
11 incentive to help push that increase in individuals
12 who are vaccinated.
13 So, you may see as we work
14 towards developing that program some more information
15 about that.
16 MR. CAUDILL: Okay. All right.
17 Then, that's all under Old Business unless someone
18 can think of something that should be addressed under
19 Old Business.
20 That being said, then, let's go
21 to Item 5 on the agenda which is New Business. The
22 first item is a presentation on the payment
23 methodology for same-day multiple visits.
24 The Honorable Gene Smallwood, a
25 former Justice and practicing attorney, will present

1 that. And the reason we're doing that is this has
2 been a subject that has come up in the MAC meeting
3 and other forums and we're trying to legitimize that
4 discussion by providing some actual background upon
5 which it could be based.
6 So, it will take about ten
7 minutes; and at this time, I will turn this over to
8 Mr. Smallwood to make his presentation.
9 MR. SMALLWOOD: Good morning.
10 As Mike said, I'm Gene Smallwood. I'm an attorney
11 with Steptoe & Johnson out of their Eastern Kentucky
12 office.
13 We also have offices in
14 Lexington and Louisville. Outside of Kentucky, we
15 have offices in West Virginia, Ohio, Pennsylvania,
16 Colorado and Texas where we engage in legal work
17 involving medical clinics, hospitals and long-term-
18 care facilities, among other areas of the law.
19 I appreciate the opportunity to
20 address the Primary Care Technical Advisory Committee
21 and the others who are participating this morning on
22 this topic.
23 As Mike said, he asked me to
24 discuss and compare Kentucky's Medicaid payment
25 approach for multiple encounters which occur on the

1 same day, by the same Medicaid patient but by
2 different medical or behavioral providers.
3 And let me begin my discussion
4 by setting a context with regard to the discussion.
5 Nationally, FQHC's and rural health clinics provide
6 medical care to one out of six Medicaid patients.
7 In Eastern and rural Kentucky,
8 the Medicaid patient load is substantially higher -
9 as much as one out of two encounters are Medicaid
10 patients - due to the elimination of the coal
11 industry in Eastern Kentucky and the effect of the
12 pandemic which has greatly reduced employment in our
13 area.
14 Under federal law, states are
15 required to establish a per-visit baseline payment
16 rate which is equal to 100% of the FQHC's average
17 costs incurred during base years, which are 1999
18 through 2000, which are reasonable and related to the
19 cost incurred by the clinic in providing the covered
20 services.
21 Federal law requires state
22 Medicaid agencies to pay health care centers a PPS
23 rate for each face-to-face encounter between the
24 Medicaid patient and one of the health care clinic's
25 medical and behavioral providers.

1 However, CMS currently
2 authorizes states to limit the number of encounters
3 paid for differing encounters by the same patient and
4 occurring on the same date.
5 In preparing for this
6 presentation, I have reviewed state regulations and
7 state Medicaid manuals regarding Medicaid payments
8 for encounters which occur on the same date in twenty
9 states, selected at random and including Kentucky, to
10 determine how the other states are handling the
11 federal law mandates and compared them with
12 Kentucky's approach.
13 For purposes of comparison, I
14 have prepared two charts, one of which demonstrates
15 the limitations upon same-day encounter payments as
16 set out in those regulations or governing manuals,
17 and a second chart to show the specific services
18 authorized for payment----
19 MR. CAUDILL: Gene, I'm sorry to
20 interrupt. We need the screen-sharing to be
21 activated. Currently it's disabled. We're not able
22 to upload the charts that Gene will be referring to.
23 MR. SMALLWOOD: There we go.
24 MR. CAUDILL: I'm sorry.
25 Please continue.

1 MR. SMALLWOOD: Thank you, Mike,
2 because the charts are the important information that
3 I want to pass along and what I have discovered.
4 The first chart, as you note,
5 deals with the number of encounters paid, and the
6 second chart deals with the types of encounters that
7 are paid.
8 Let's look at the first chart
9 which concerns a number of paid encounters permitted
10 by the states.
11 Generally, all of the states I
12 reviewed require the following factors to occur to
13 constitute an encounter eligible for payment.
14 The first encounter has to be
15 face-to-face. It must be performed by a different
16 medical or behavioral provider, requires a different
17 diagnosis code be used in reporting the claim for
18 payment, and a separate filing or claim be submitted
19 for each encounter on the same date.
20 All of the states which I
21 reviewed, including Kentucky, pay for a second
22 encounter on the same date if the treatment is for a
23 subsequent injury or illness which caused the patient
24 to return to the clinic after the initial treatment
25 on that same date.

1 As the chart on the top
2 demonstrates of the twenty states I reviewed, fifteen
3 states pay for three or more encounters which occur
4 on the same day, providing the encounters are for
5 different services and result from different
6 diagnosis.
7 Generally the states pay for
8 one encounter for medical services, one for
9 behavioral services and one for dental services.
10 Of those fifteen states, three
11 states - Oregon, Washington and Ohio - provide
12 payment for an unlimited number of encounters
13 occurring on the same date. Again, they have to be
14 based on different services provided for different
15 diagnoses.
16 And that's why I stopped at
17 twenty states because it was apparent that there was
18 a dominant pattern that most states, by in large, pay
19 for up to three encounters occurring on the same
20 date, provided that these encounters are for
21 different services with different diagnoses.
22 As you will note on the chart,
23 Kentucky stands alone as the only state which limits
24 payments for only one encounter per day, and that is
25 a dramatic difference in what is occurring in other

1 states.

2 The effect of Kentucky's
3 approach as compared to the other states' approach,
4 it's apparent. For many of our patients in Eastern
5 and rural Kentucky, and particularly the elderly and
6 those on fixed incomes, the cost required to travel
7 to the medical facility to receive treatment is
8 difficult and expensive.

9 In the absence of mass
10 transit, it often requires hiring someone to
11 transport the patient to the clinic which in some
12 instances can be a distance of forty-five miles or
13 more from their home.

14 To minimize this expense, the
15 Medicaid patient will often schedule more
16 than one encounter for different services on the same
17 day at the clinic.

18 Since Kentucky pays for only
19 one encounter per day, the expenses involved in the
20 second or additional encounters the patient receives
21 on that same day is a cost incurred by the clinic
22 without any opportunity to receive Medicaid
23 payments for those medical or behavioral or dental
24 services which are provided.

25 In a market where medical

1 provider costs are already higher than the
2 national average, due to the difficulty in obtaining
3 and retaining qualified medical providers to serve in
4 depressed and rural areas, the cost for these
5 unpaid encounters cuts deeply into the budget of
6 FQHC's or rural health clinics.
7 Now, let's look at the other
8 chart which demonstrates the particular services that
9 are authorized by the various states for Medicaid
10 payment for multiple encounters.
11 First off, you'll note that I
12 didn't list any for Kentucky because Kentucky only
13 pays for one encounter regardless of what the nature
14 of the encounter is.
15 Of the twenty states that I
16 reviewed, fifteen of the states pay, in addition to a
17 medical encounter, for a behavioral encounter and a
18 dental encounter which occur on the same day.
19 However, a few states, as you
20 will note, will also pay for optometry or
21 ophthalmology services.
22 Some states like Oregon pay for
23 multiple encounters on the same day but only for
24 specific, enumerated areas of practice set out in the
25 regulations.

1 Encounters outside of those
2 areas of medical services which are not identified in
3 the regulations are not paid.
4 Other states like Washington
5 and Ohio only require that the multiple encounters
6 involve different services with different diagnoses
7 in order to provide payment.
8 It is important to note that
9 some states include OB/GYN services in their
10 definition of a medical encounter.
11 Under this restrictive
12 definition, a FQHC or Rural Health Clinic which
13 treats a Medicaid patient for a medical encounter,
14 and, then, on the same day, also treats the patient
15 for an OB/GYN issue, would only receive payment for
16 one encounter.
17 Other states, however, treat
18 OB/GYN services as a specialty service apart
19 from medical services and authorize payment for that
20 initial encounter.
21 While limiting payment to no
22 more than three specified and different encounters on
23 the same date is not ideal, it is certainly a vast
24 improvement over Kentucky's restricted approach of
25 only one payment for all encounters occurring on the

1 same date regardless of the services provided or the
2 diagnoses.
3 A review and comparison of the
4 other states’ approach in paying for multiple
5 encounters on the same date demonstrates that
6 Kentucky is lagging far behind its neighboring and
7 other states in the Medicaid payment approach.
8 The ramification of Kentucky’s
9 restricted approach is that Kentucky’s FQHC’s and
10 Rural Health Clinics have no state financial
11 incentive to expand their services beyond basic
12 medical care or to expand their physical locations to
13 new or other under-served areas because the funding
14 for these expansions are otherwise diverted to pay
15 the costs incurred in providing the multiple-
16 encounter care on the same date to their patients for
17 which they receive no pay.
18 This directly and adversely
19 limits the access of Kentucky’s residents in Eastern
20 and rural Kentucky in receiving the health care they
21 require and increases their cost to travel and
22 receive that care.
23 A comparison of how other
24 states approach Medicaid payments for multiple
25 encounters on the same date should cause us in

1 Kentucky to examine Kentucky's approach and its
2 adverse effect on residents in Eastern and rural
3 Kentucky. It should cause us in Kentucky to revise
4 our payment approach so that it is at least at the
5 level of most other states, and particularly
6 including our neighboring states, so that our
7 residents have access to health care at least at the
8 same level provided in neighboring states.
9 Revising Kentucky's approach to
10 providing Medicaid payments for up to three
11 encounters on the same date, one for medical
12 services, one for behavioral services, and one for
13 dental services, would increase the opportunity to
14 provide greater access to care for Kentucky's
15 Medicaid patients and improve their level of health,
16 while, at the same time, reducing patient costs to
17 obtain that care.
18 Are there any questions with
19 regard to the information on these charts and what
20 I've talked about this morning?
21 MR. CAUDILL: And let me be very
22 clear in this. Certainly, it is our policy at MCHC
23 and I'm sure the policy of everyone else, we do our
24 best to see every patient for whatever needs they
25 come in. We refer to ourselves as a one-stop shop

1 because we're proud of the fact that we work hard to
2 meet these needs.
3 However, less resources means
4 less services regardless of our attempts, and the
5 converse of that is more resources, the more services
6 that we can do.
7 So, it's not a matter of what
8 we're doing as much as what are the limitations on
9 being able to do that.
10 So, this is why I asked Gene to
11 review this and do a presentation so we can have this
12 conversation and what has been alluded to and talked
13 informally about across the state.
14 So, at this time, are there any
15 questions from anyone concerning Gene's presentation
16 they would like to ask?
17 MS. KEYSER: Mike, this is
18 Chris. I've got just a quick question. What would be
19 the necessary steps for Kentucky Medicaid to consider
20 a change? Is there some formal adoption that has to
21 come from CMS for them to do this or is this a
22 contractual change?
23 I'm just looking for some more
24 information and maybe somebody from Medicaid can give
25 us an idea as far as what would be a formal way of

1 having Medicaid consider this.

2 MS. CECIL: Obviously, there's a
3 budgetary impact to it. And, so, we would have to do
4 that analysis.

5 My understanding, the last time
6 we looked at this, is that less than half of the
7 states permitted more than one encounter on the same
8 day.

9 I know that you did good
10 research possibly to the extent possible and came up
11 with twenty, but that means over half of the states
12 still may not permit an encounter, but there is a
13 budgetary impact to that.

14 I think what we have to really
15 analyze is the point of the rate is to cover costs.
16 It's developed based on cost of services being
17 provided and we have to take that back, and if
18 there's an issue with the rate isn't covering the
19 cost, then, we have to look at that.

20 MR. SMALLWOOD: If I could
21 address that point as well. I would be glad to look
22 at the other thirty states and report back. I just
23 did not see any evidence that half or more were only
24 paying for one encounter.

25 I pulled twenty states

1 randomly, tried to pull the states around Kentucky in
2 particular so you could see what our neighboring
3 states are doing, and it's clear that there is a
4 great preponderance to pay for three encounters or
5 more. And those budgetary issues that our state face
6 are also faced in those other states.
7 Specifically with regard to the
8 question that was posed, Kentucky's payment approach
9 is set out in our regulations, 907 KAR 1:055. I
10 would think it would require a regulation change and
11 the administrative process would have to be gone
12 through in order to make the change so that Kentucky
13 would be in parity with the states that I have
14 presented in this regard.
15 MS. CECIL: We would also need
16 CMS authority. So, we would have to file a State
17 Plan Amendment.
18 MR. CAUDILL: And I think that's
19 what we're looking for is to give a heads up for the
20 Department so that they can have an opportunity to do
21 their own review and verify the information given
22 here.
23 And it's my understanding that
24 there is talk that something along these lines may be
25 an issue addressed in the next Legislature.

1 So, these are very early steps
2 in looking at this and a lot of different factors and
3 a lot of different stakeholders have to have the
4 opportunity to look at it and make a reasonable
5 appraisal as to what the effects would be and the
6 desirability of that type of change.
7 So, this is just a place to
8 start to see how it develops.
9 MS. CECIL: If the information
10 could be shared with us, especially those charts,
11 that would be helpful.
12 MR. CAUDILL: Absolutely, we can
13 do that. In very short order, we will get it to you.
14 MS. CECIL: Thank you.
15 MR. MARTIN: And did you have
16 any research on the methodology of how they reimburse
17 for the three or more encounters?
18 MR. SMALLWOOD: It is my
19 understanding, and I did not look specifically at
20 that point, but they are paid at the same rate, that
21 each encounter is treated the same, so, it will be
22 the same payment for each encounter.
23 Now, I will readily admit I did
24 not go into depth with regard to looking at that, but
25 that appeared to be the case from the review of the

1 statute or the manuals that I looked at.
2 MR. MARTIN: Thank you.
3 MR. CAUDILL: So, then, having
4 finished that and there not being any further
5 questions, let's move on to the agenda, then, under
6 5B, Updates or Announcements from the MCOs.
7 And to that end, we will follow
8 the same order we did last time. Anthem, is there
9 anyone who would like to report? The last time you
10 had a website redesign that was going to go active as
11 of April 18th and you had a provider coding education
12 series live. Would you like to bring us up to date
13 on what's going on?
14 MS. SMITH: This is Jennifer
15 with Anthem. So, to follow up on your point, the
16 Medicaid website, the enhancements that are being
17 launched, they are actually expected to be launched
18 now in June. So, next month they should be live.
19 So, just a reminder on that.
20 I did want to let you guys know
21 that in order for us to communicate more efficiently
22 with providers, we are now sending some bulletins and
23 policy changes, prior authorization updates,
24 educational opportunities to providers via email.
25 So, that is new.

1 So, in order to receive an
2 email from Anthem, we do ask that you update your
3 email address. We are a provider maintenance
4 (inaudible) and there are additional details around
5 all the information that's going to be expected, that
6 you expected to see in our May, 2021 newsletter that
7 was just launched.
8 And, then, also, I wanted to
9 let you guys know that Availity is now offering an
10 appointment scheduler for Medicaid. So, this is very
11 new and it's going to be offering many features.
12 So, providers are going to be
13 able to manage appointments a lot easier. Members
14 can be notified directly via text or email once the
15 appointment is confirmed. And, then, we can also
16 send appointment reminders. And, again, this
17 information is located on our May, 2021 newsletter.
18 And, then, the last item that I
19 wanted to make you guys aware of, Anthem has launched
20 a new provider experience model that has already been
21 launched throughout Anthem enterprise wide and it is
22 going to cover all lines of business.
23 So, the initiatives underway
24 are really designed to really improve and simplify
25 processes that are most impactful to you and

1 eliminating any administrative burden.

2 So, we're focusing on more

3 informed and faster service, more education and

4 faster training, providing access to performance data

5 and just better navigation of issue resolution, and

6 that's all I have.

7 MR. CAUDILL: Okay. Thank you.

8 Any questions?

9 MS. KEYSER: Yes. This is

10 Chris. I've got a question for Jennifer.

11 Can you go a little bit more

12 into detail? I was a little confused about setting

13 up appointments on Availity for patients, one, the

14 necessity of doing this when providers have their own

15 appointment systems in their EMR and they're able to

16 send text reminders and email reminders to patients

17 about appointments. You kind of lost me on the

18 functionality and the why of that.

19 MS. SMITH: Again, if you have

20 your own system set up, you can still use that. This

21 is just an additional feature that we have launched

22 within the Availity portal.

23 So, if you don't have those

24 options currently available or if you're having

25 issues with it, you can utilize this feature through

1 Anthem. You don't have to but it is something that I
2 just wanted to let you know that you have available
3 to you.
4 So, it's probably similar to
5 what many providers are using now but it's just
6 another option that's available.
7 MS. KEYSER: Okay. Thank you.
8 MR. CAUDILL: Thank you for that
9 presentation. We'll go to WellCare, and the last
10 time they were talking about their National Imaging
11 Association agreement to take over the radiology
12 benefit management. How is that going for you?
13 MR. AKERS: First of all, Mike,
14 this is John Akers from WellCare. So, we did
15 transition some of our imaging services over to NIA
16 and we have been working through a few initial issues
17 and working those out. And if anyone has any
18 particular issues you're having with NIA, please feel
19 free to outreach to me or Tony Peagitini or your
20 local PR rep.
21 Regarding announcements, as we
22 did last year, because of the public health
23 emergency, our annual provider summits are going to
24 be virtual again this year, and the first one coming
25 up on May 14th.

1 So, on May 14th, from 12 to
2 1:30 - that's next Friday - we will have our virtual
3 provider summit. And, hopefully, after the public
4 health emergency is over, we'll be able to move those
5 back to having those in person. If you need the
6 calendar invite, you can reach out to me if you want
7 to or your local PR rep and they can share that
8 calendar invite with you.
9 MR. CAUDILL: All right. Thank
10 you, Johnie. Any questions for Johnie?
11 All right. Let's go to Aetna,
12 and the last time, they were talking about their
13 Supporting Kentucky Youth or SKY Program.
14 MS. ROSE: Good afternoon. This
15 is JoAnn Rose. I'm the Network Manager for the PR
16 team here at Aetna Better Health of Kentucky.
17 And kind of going along the
18 lines with the Supporting Kentucky Youth, we just
19 want to let you guys know that we are offering our
20 virtual office hours. We do this every other
21 Thursday. It's an hour-long session.
22 Several folks from our PR team
23 are on there. The hour contains information. The
24 first part we've been focused on SKY. Moving on to
25 the month of May, there's going to be a billing and

1 claims component. So, there will be some training
2 topics on there, as well as, again, the PR team will
3 be on there to discuss any issues that may arise.
4 And also it's open dialogue.
5 So, it allows for partnership and collaboration
6 between the Network Relations' PR team and the
7 provider. So, we hope providers find it's
8 informative and a great way to really interact.
9 We have all the events on the
10 Events' page at our website, or if you need that
11 link, you can reach out to your Network Relations
12 Manager which is also on the website.
13 MR. CAUDILL: Any questions for
14 JoAnn? Thank you, JoAnn.
15 Now Humana Healthy Horizons,
16 and last time, they reminded us that the timely
17 filing is 365 days as of July 1 of 2020 but also
18 talked about the shift from denials from the Master
19 Provider List to the system more similar with the
20 previous Humana CareSource and warned us that there
21 might be some confusion when we get a report from the
22 clearinghouse because of that.
23 If someone is on here, would
24 you care to address how that is working out for you
25 and any other items you'd like to state.

1 MS. DAY: This is Beth Day with
2 Humana Healthy Horizons. So far so good in
3 rejections for the Master Provider List. We are
4 making available to our providers their information
5 that is on the Master Provider List and that is
6 something that you should be receiving quarterly from
7 your representative.
8 And as far as new updates go, I
9 did want to share with you some value-added services
10 that we've been approved by DMS to provide to our
11 Medicaid membership, and there is a provider guide on
12 our website called Value-Added Services' Provider
13 Guide and that has FAQ's around these. It has visit
14 limits, age limits and claims submission tips.
15 The additional services that
16 are able to be provided this calendar year for our
17 members are dual services, chiropractic services,
18 acupuncture services and sports physicals.
19 I know that we did get the
20 approval to do these a little bit late in the year
21 but there is still a better-than-half portion of the
22 year left to be able to provide these additional
23 services to our membership and we're excited to be
24 able to partner with you guys for those kinds of
25 treatments.

1 MR. CAUDILL: Any questions for
2 Beth? Thank you.
3 Next is Passport Health Plan by
4 Molina Healthcare, and last time you were talking
5 about your open mic for providers that's been done on
6 a biweekly basis. Is that still continuing and any
7 other issues or matters you'd like to bring up with
8 us today?
9 MS. FIFE-CARRIER: Thank you.
10 Yes, those are still going on based on provider type.
11 That way we're not wasting anyone's time and they
12 don't have to listen to other specialties.
13 Also, we wanted to bring up
14 that this Saturday, we're hosting a free COVID
15 vaccination workstation centrally located in
16 Louisville and there also will be food trucks. We
17 sent that blast out to most of our providers.
18 We have communicated with all
19 of our providers that we have a clean check
20 disbursement turnaround time that's averaging less
21 than ten days for all clean claims. So, it's
22 something that we're a little proud of.
23 We have also added a social
24 determinant of health to our members' packets. That
25 way, we know who is at higher risk. We're also

1 asking hospitals that support the (inaudible)
2 admissions to do the same assessment at the time of
3 discharge. That way we're hopeful in working towards
4 getting our beneficiaries to get connected with
5 services within their community to kind of drive down
6 the chances of readmission.
7 That's all from Passport.
8 MR. CAUDILL: Okay. Are there
9 any questions, then, for Shelley?
10 All right. Then, we move on to
11 United Healthcare, and they were discussing having to
12 work through some bugs for their go-live date. Would
13 you like to go ahead and speak to that, whoever the
14 representative might be?
15 Do we have anyone on here from
16 United Healthcare? Okay.
17 Then, we'll move back to our
18 agenda which is 5C, Recommendations to the MAC.
19 So, based upon the presentation
20 that Mr. Smallwood did, let me suggest one for the
21 Board's consideration.
22 I would suggest the following
23 recommendation. It is this committee's
24 recommendation to the MAC that they request DMS to
25 review their same-day multiple visit payment

1 methodology and report back to the MAC comparing
2 Kentucky's methodology of that of surrounding and
3 other states to determine if Kentucky's approach is
4 in parity with the majority of other states, and if
5 not, to suggest an approach for Kentucky to become
6 more mainstream with the trends across the country in
7 reimbursement for same-day multiple visit payment
8 methodology.
9 Having said that, would any of
10 the committee members like to comment on that or to
11 adopt that in a motion to approve that as a
12 recommendation for the MAC?
13 MS. AGAN: Mike, this is Yvonne.
14 I would like to move that we make that recommendation
15 to the MAC as you presented.
16 MR. MARTIN: I'll second it.
17 MR. CAUDILL: We have a motion
18 made by Yvonne and seconded by Barry. Is there any
19 discussion? There being none, I'll call that for a
20 vote. Those in favor of the recommendation as
21 presented say aye. Those opposed likewise. Motion
22 carried unanimously.
23 The next item is 5D,
24 confirmation of Chair to attend the MAC meeting which
25 will occur on May 27th from 10:00 to 12:30. I do not

1 have a conflict. I can attend. If somebody would
2 want to attend instead of me, I certainly will yield
3 to that. Otherwise, I will be in attendance. I will
4 be in attendance at that.
5 New Items for Discussion. We
6 talked earlier just as a followup on the idea of how
7 well the COVID vaccine is going in Kentucky.
8 I can tell you that what we
9 have given out earlier is dropping off. Just a
10 summary for MCHC, we gave out 1,174 J&J, 10,279
11 Moderna and 96 Pfizers.
12 We're seeing the trend now as
13 dropping off from a high of I think over 1,200 in a
14 week and I think last week we did about 400. Whether
15 it's resistance or what, we're finding it harder and
16 harder.
17 Also with the reducing of the
18 age so that you can do sixteen and above, we've
19 approached school systems and our feedback has been
20 almost no interest in those of age students taking
21 it. In the Letcher County system - there's 1,200 or
22 so students - only four expressed an interest in
23 having it, being polled through the school.
24 Is that consistent trends with
25 what other people are seeing that is administering

1 the vaccine?

2 MR. MARTIN: Yes. Ours is

3 mirroring that as well. I think we've hit a

4 saturation mark.

5 MS. KEYSER: I think it also is

6 in regard to COVID testing as well. Our COVID

7 testing has really dropped off. Again, it's waning

8 terribly.

9 In Warren County, I will say

10 that our local regional hospital, The Medical Center,

11 is providing clinics in the school systems. I can't

12 tell you how well they're being received.

13 I know that, again, it takes

14 parental consent for those to happen. I think for

15 the most part, they're getting it done. Parents are

16 getting it done, particularly with getting ready for

17 the new school system for the fall, that kind of

18 thing; but I think, again, just overall, everybody is

19 tired and it's getting harder to keep the interest

20 going.

21 A vaccination that requires the

22 second shot, people not coming back in for the second

23 shot, chasing them down, that type of thing, yeah, I

24 mean, I think those are just some of the challenges

25 that are real in communities.

1 MR. CAUDILL: I think one of the
2 greatest telling things is we had an opportunity to
3 give out fifty shots on one day back in January and
4 it snowed. Forty-nine of those people showed up to
5 take it, and we later found out the fiftieth also
6 came and took it but they took it through other than
7 our lines. They went through another line for the
8 testing and they gave it to them there.
9 And that was eighty and above
10 at that time and those are the people that do not
11 come out in bad weather. I think that demonstrates
12 just how important it was. Now just scheduling
13 people to come in on these bright sunny days, we'll
14 have 40% no-shows.
15 It's just the change in the
16 attitude of people. Those people who want it,
17 believe in it seems to have acquired it at one place
18 or the other. And the people now are resistant or,
19 while not being resistant, they're just laissez faire
20 about it, just not really as important as it once
21 was.
22 MS. KEYSER: I'm happy to say
23 that at least in Warren County and this area, we have
24 plenty of providers being able to give the vaccine,
25 particularly through pharmacies. The expansion into

1 pharmacies really opened up a lot of doors.
2 And, again, in our area, we
3 have a vaccine clinic that's out at our mall in the
4 old Sears building and it's Thursday, Friday and
5 Saturday. I think you can walk in on any of those
6 days and you can get in line and get a shot.
7 And, so, I think the big part
8 is how do you keep the momentum going because they've
9 made it pretty easy for anybody to just walk in.
10 It wasn't like in the beginning
11 where you had an appointment months out or weeks out.
12 Availability is readily there.
13 So, I think those are, again,
14 just challenges to what healthcare providers are
15 doing.
16 MR. CAUDILL: So, from the
17 Department, hearing this, is this consistent with the
18 feedback that you're getting across the state? And
19 is the Department having any planning sessions to try
20 to motivate people, either change their mind from the
21 resistance crowd or to encourage those that are not
22 really that much into it? What's going on with the
23 Department in this regard?
24 MS. CECIL: Absolutely we are
25 concerned and that's why we've been in conversations

1 with the Managed Care Organizations to offer some
2 incentives and to increase outreach.
3 And I do believe the State has
4 tried to communicate a little better about - well,
5 better may not be the right word - but differently
6 about the importance of the vaccine to try to get
7 over this hesitancy hurdle.
8 So, there's been increased
9 outreach. I think the difficulty is - Ms. Keyser,
10 you mentioned this - is that the people that were
11 getting tested are the people who really came up
12 first to get vaccinated because they're the most
13 concerned, and I think that's why we're seeing now an
14 enormous decrease in the testing for it.
15 But, yes, I think we're very
16 concerned, very concentrated on it and have been
17 trying to look at ways to encourage folks to get that
18 vaccine.
19 I do appreciate the innovation
20 or I guess thinking outside the box of providers,
21 going and doing it at churches. I know here in
22 Frankfort, the local Health Department is going to
23 like four or five churches and having events at those
24 churches to try to get at least the membership from
25 those churches to come and get vaccinated.

1 So, those are what we're going
2 to have to do now that we've got the individuals who
3 were most concerned and most interested in getting
4 that vaccination is how do we make that available in
5 the community, in the neighborhood and that's what
6 we're working on.
7 MR. CAUDILL: I wonder if there
8 could be some advertisement aimed at motivating
9 people. I don't know, maybe if some of our
10 recognized sports figures or personalities would do
11 the fifteen-second for it to be put on television and
12 radio - I had mine and it's important that you have
13 yours - if that might help in some ways; but,
14 obviously, at this point, we're digging them out.
15 We have some mobile vans, and
16 at this point, if two people stop for a conversation,
17 we'll try to show up and offer it to them and we've
18 gone to country stores and employers, jails, centers
19 of government, churches and, still, you're getting
20 the resistance.
21 We tried to schedule with a
22 large church and there was not enough people even
23 interested in it. Out of several hundred members,
24 there was only like three or four people that were
25 interested in getting it. So, we made arrangements

1 for them but it was not feasible to go ahead and try
2 to just drive over there for them but we did get them
3 their shots.
4 MS. CECIL: And I do know what
5 has happened over the past couple of weeks, there was
6 an event in the west end of Louisville. They were
7 able to identify phone numbers and do a call out to
8 people and reach out to help people schedule that
9 vaccination and to encourage them to attend the
10 community event.
11 And, so, those are the things
12 that we're working on. Information is always the
13 challenge on the front end trying to identify or get
14 contact information for people and reach out to them.
15 And, then, on the back end,
16 it's, again, trying to incentivize members or
17 providers. With the members on the back end, it is
18 giving them an incentive for having completed the
19 vaccination and how do you verify that. There is a
20 vaccine card, but we're trying to figure out what's
21 the best way to verify that information.
22 So, we're trying to work
23 through all of those and be as creative as possible
24 and trying to overcome what we're seeing as the drop-
25 off.

1 MS. AGAN: (Inaudible).

2 MS. CECIL: Absolutely. As you
3 mentioned, I think they have identified figures that
4 are role models, both I think well-named and those
5 that represent the population, especially from a
6 diversity standpoint.

7 And, so, there's a lot of that
8 going on in phases but what we have to figure out is
9 how do we get that out into, again, the community or
10 on TV so that we're reaching people where they are
11 and how they access that information.

12 I think our greatest push will
13 come from including community leaders and faith
14 leaders and our advocates, our advocacy organizations
15 in trying to make it not so scary and try to
16 encourage that vaccination to happen.

17 MR. CAUDILL: Good discussion.
18 Is there anyone else who would like to comment?

19 MR. MARTIN: I think we're to a
20 point where it's going to have to be financially
21 driven, some kind of competition to get vaccinated or
22 the Governor's Office start saying that counties that
23 have a low positivity rate can start opening up.

24 There has to be some kind of
25 financial incentive, and I think the latter would be

1 the way to do it is look at counties and say if you
2 have an "x" positivity rate, then, your restaurants
3 can open up, you can start having meetings, open
4 meetings. I think doing a pilot of like ten
5 counties, I think that would be a good trial-and-
6 error method.
7 MS. CECIL: We appreciate that
8 suggestion.
9 MR. CAUDILL: To continue the
10 discussion, then, a little bit further. It looks
11 like we can give the vaccines down to sixteen-year-
12 olds and it looks like that's going to go on down to
13 twelve-year-olds.
14 With that group, the common
15 denominator is they all go to school. I know in the
16 past, there's been some often-ignored regulations.
17 They had to have certain vaccines before they could
18 start school each year.
19 Is the Department looking at
20 that possibility of maybe some regulations that would
21 require students to get it unless they fall under one
22 of the usual exceptions?
23 MS. CECIL: Well, the Department
24 for Medicaid Services doesn't have that authority.
25 That's a Department for Education or the Governor, I

1 think, but, again, I think that's a suggestion that's
2 worth exploring.
3 MR. CAUDILL: Kids, right now
4 we're going through the prom and we've shown a little
5 bit of an uptick that we're tracing back to kids
6 going to the prom and spreading it that way.
7 Okay. If there's no further
8 discussion, are there any other new items that would
9 like to be addressed?
10 MS. CECIL: Mr. Caudill, if you
11 don't mind, I would like to give an update on the
12 Managed Care Organization Pharmacy Benefit Manager
13 implementation.
14 Just to let you all know, we're
15 moving towards July 1st. We shared a letter last
16 month with I think the MAC and all the TACs about the
17 implementation and some webinars that are going on
18 right now.
19 I'm happy to re-send that, re-
20 share that, kind of put it on top of everybody's
21 email. The next webinar is May 14th from 4:00 to
22 5:00 and it's for all providers, not just pharmacy,
23 and, so, prescribers accessing that.
24 There's another one on June
25 15th from 1:00 to 2:00 and, again, I'm happy to send

1 that back around.

2 I'm cautiously optimistic that
3 things are going well. What we're really focused on
4 right now is - of course, we already have the single
5 PDL. So, that transition is pretty easy to the new
6 PBM.

7 What we're looking at is non-
8 PDL items and over-the-counter items and making sure
9 because the MCOs had different policies around that.
10 So, the Department is looking at that and making sure
11 that there is consistency. So, we're reviewing those
12 right now.

13 And we are working on a
14 prescriber letter that will go out hopefully before
15 June 1st to the providers. So, I just wanted to put
16 that on your all's radar and let you all know that
17 that's going on.

18 It's the first in the country
19 to have this kind of model. So, it is very different
20 and that means that some of the decisions we're
21 making had to be thought about. And it's a little
22 different because any Medicaid-enrolled pharmacy
23 becomes the network.

24 So, in the past, I know MCOs
25 might have had different networks, especially around

1 mail order or specialty. The way that we're doing
2 it, it is the fee-for-service network which is any
3 Medicaid-enrolled pharmacy provider.
4 So, that's going to be very
5 different, but what we hope for some administrative
6 simplification is that we'll now have just the one
7 PBM that you'll have to deal with and we think that's
8 going to be better for providers.
9 MR. CAUDILL: Thank you for
10 bringing that to our attention. It would be good if
11 you don't mind re-sending those things. Any
12 questions or comments for Veronica?
13 MS. AGAN: Thank you for sharing
14 that.
15 MR. CAUDILL: Chris, did you
16 have something?
17 MS. KEYSER: No. I was just
18 going to say I appreciate that. I think overall
19 that's a worthwhile change that providers are excited
20 about.
21 MR. CAUDILL: Okay. Are there
22 any other items for discussion that would like to be
23 brought up by anyone?
24 The next meeting for the PCTAC
25 will be July 1st of this year, of course, from 10:00

1 to 12:30.

2 MS. KEYSER: Mike, this is

3 Chris. I'm just letting you know I will not be able

4 to attend that meeting.

5 MR. CAUDILL: Okay. Chris

6 cannot attend. Thank you, Chris.

7 There not being any other

8 items, Item 6, then, is Adjournment. Would anyone

9 like to make that motion?

10 MS. AGAN: I make that motion.

11 MR. MARTIN: I'll second it.

12 MR. CAUDILL: Motion made by

13 Yvonne, seconded by Barry. All those in favor say

14 aye. Have a wonderful day, everybody.

15 MEETING ADJOURNED

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