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

IN RE: PRIMARY CARE TAC SPECIAL-CALLED MEETING

October 5, 2020
10:00 A.M.
(All Participants Appear Via Zoom or Telephonically)

APPEARANCES

Mike Caudill
CHAIRMAN

Yvonne Agan
Chris Keyser
Raynor Mullins
Barry Martin
TAC MEMBER PRESENT

Noel Harilson
Mary Elam
Teresa Cooper
David Bolt
Edward Conners
Zach Sturgill
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APPEARANCES
(Continued)

Stephanie Bates
Veronica Judy-Cecil
Angela Parker
Steve Bechtel
Judy Theriot
Sharley Hughes
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 Quorum

3. Review and Approval of previous transcript - September, 2020

4. OLD BUSINESS:
   A. Report on wrap/crossover claims cleanup July 1, 2014 to June 30, 2018
   B. G2025 telehealth code not being recognized - concern with effective date of 7/1/20. This differs from the latest CMS letter.
   C. DMS limitation on thirty site NPIs - update from DMS

5. NEW BUSINESS
   A. No-show screen on KY Health Net - further detail provided to PTAC
   B. RHC/FQHCs remaining distant site for telehealth services in Kentucky post-PHE
   C. Issues related to potential payment processes that could affect FQHCs/RHCs - duplicate logic 5001 encounters
   D. Updates or Announcements from the MCOs
   E. Recommendations to the MAC
   F. Next Meeting - schedule meetings for the next calendar year

6. Adjournment

CHAIRMAN CAUDILL: As the Chair of the Primary Care Technical Advisory Committee, I would call this meeting to order. Clocks may differ but it looks like 10:03 a.m. to me.

We need to establish a quorum.

MR. HARILSON: We have a quorum.

CHAIRMAN CAUDILL: At this time, has everyone had a chance to review the previous meeting transcript that was sent out? If so, at this time, are there any modifications or changes to be made, and if there's not, would someone like to move to approve the September, 2020 meeting minutes as provided by transcript by Sharley?

MS. KEYSER: Mike, this is Chris. I'll make a motion.

MR. MARTIN: I'll second it.

CHAIRMAN CAUDILL: Motion made and seconded. All those in favor? All those opposed, a like sign. There being no opposition, the motion carries unanimously.

Let's move on to the Old Business and the first item there is report on the wrap/crossover claims cleanup July 1, 2014 to June 30, 2018.

MS. HUGHES: Raynor just joined.

CHAIRMAN CAUDILL: So, we have everyone in attendance. So, for Raynor's benefit, we have just started discussing Old Business, Item 4A report on wrap/crossover claims cleanup July 1, 2014 to June 30, 2018.

It's my understanding that in the interim, that the KPCA in the form of John Inman and Teresa Cooper presented at the Medicaid Oversight Advisory Committee on October 28th. They did a slide presentation and that link is available if anyone wants to look over those.

It's my understanding that the presentation was focused on the Prospective Payment System which is currently being used to reimburse federally qualified health centers and rural health clinics.

This is basically what we call our wrap payment or a supplemental payment where DMS pays an amount up to the PPS rate that the MCO did not pay completely. They pay the fee and, then, DMS pays the difference between their fee and the PPS rate.

There was some criticism of this process from John Inman that it is inefficient and that, in fact, many payments are still owed by

DMS at this time to the individual clinics.

The payment process was on Slides 5 and 6 of the presentation, and KPCA suggested the following to resolve the backlog in payments. It says currently only the encounters paid by the MCOs that make it across the threshold are paid the supplemental payment, and some clinics have losses dating back to 2014.

It also points out that only one set of data exists to compare the claims when most states have two sets of data to compare the claims submitted.

KPCA said that they have done extensive research and retained legal counsel to provide DMS with reconciliation methodologies from different states for review and consideration, and they want to be able to work with DMS to develop a system to reconcile claims submitted by clinics to the MCOs and the supplemental payments made by DMS to the clinics which would include utilization of a centralized data system with additional funding to aid in the process.

At that time, I believe, Senator Meredith had asked some questions including total for the outstanding payments which KPCA did not

have exact information but cited that one of the largest FQHCs is owed $6 million.

They suggested that the Texas model has been the best model, and I'll also point out at this time under the current system that the MCOs have no incentive to assist, and, as a matter of fact, they actually may be penalized to some degree.

That was responded to by Commissioner Lee who stated that DMS is following federal guidelines and are compliant with federal laws, and there was some disagreement with that with John Inman, but, anyway, they went on to say that DMS has engaged CMS to seek clarification and has also put together a work group within the Department to look for solutions to this issue.

They've looked at the Texas model and worked with other Medicaid Commissioners to seek information on how other states handle supplemental payments.

Senator Meredith suggested that KPCA consider legal action if the issue isn't resolved soon.

Personally, I would hate to see legal action. I think that two groups that have very much the same objective, and that is to take care of

our eligible and disadvantage people in Kentucky, should be able to work together to resolve this. Perhaps DMS would consider this workgroup to have a representative from the MCOs, or, excuse me, from the FQHCs and/or RHCs to be able to provide input from the provider side and see if that can help and maybe seeing if both sides could not come up with a solution that helps everyone.

But, again, let me reemphasize that as far as this committee is concerned, and myself as the Chairman, it is our continued desire for DMS and KPCA to resolve this issue. We have over 300 PPS eligible practices in Kentucky at this time.

Does anyone else have anything they would like to add to the report that I just gave?

MS. CECIL: This is Veronica Cecil with the Department for Medicaid Services. I'd like to provide an update. I could do that now, or if you want to get feedback from other members, I can wait.

CHAIRMAN CAUDILL: Please go ahead.

MR. MARTIN: Chairman Caudill, if you don't mind. Before Ms. Cecil says anything, I

want to say that we've reached out to DMS and actually had a conversation with Veronica and Stephanie and Steve Bechtel and it was a very productive conversation.

And I will let her update you on what all is going on, but it seems like they're on the right path, and I'd like to encourage them to continue that from the TAC's perspective and from our own providers' perspective.

So, Veronica, I'll let you go from there. I just wanted to interject that there has been some dialogue and it's been a really good dialogue.

CHAIRMAN CAUDILL: Thank you, Barry, and that's very good to know. Veronica, would you like to go ahead, then?

MS. CECIL: Yes. Thank you, and thank you, Barry. I appreciate you adding that.

Certainly, we agree with you that the best course is to work together to have a program that pays timely and accurately. And, so, that's our goal and we do share that goal, I think.

We have been doing a lot of work over the past two months. First, there was an internal meeting with DMS that included DXC, which is

now Gainwell, and OATS, our technical side because we feel like we need to have a really good understanding of what's going on because we can't come to the table and tell you whether or not we can do something.

Since then, we have met with two MCOs with their IT teams. Let me back up. As a result of that internal meeting, we asked and directed MCOs to send in everything they have related to 31 and 35, so, FQHCs and RHCs.

At that point, we didn't care how late it was. We didn't care whether it was accurate. We wanted to get everything in so that we could have a really good sample to work from to see what is going on with all of these claims and encounters.

So, MCOs did that. They dumped. They dumped encounters. And, so, we took that and created a report for each MCO and those reports, then, allowed us to see from each MCO the reasons why things may go to threshold, why things may be denied, why it looks like a legitimate encounter but the wrap is not being paid. So, it helped us identify what some of those potential root causes are.

We met with two of the MCOs and

have gone through some of that information. We have two more MCOs tomorrow and that leaves one other MCO to sit down and go over it. Again, we're working through a process.

The next step from meeting with those MCOs is to pull in KPCA and a couple of providers. You're correct, we need to have a provider perspective and we want you guys at the table to help us figure out how do we overcome this process? What is it that we can do at DMS, what is it that an MCO can do or what is it that a provider can do to try to increase the accuracy of a wrap payment being made?

So, that's where we are in terms of let's figure out, because a reconciliation doesn't solve our problems. We want you guys to get paid and we want you to get paid accurately.

And, so, we felt like we needed to have this deep dive into what's going on with the system, and there are three buckets. There's a bucket that is our system and what it's doing. There's a bucket of the MCO and what they're doing, and, then, there's a bucket of providers and how they submit the claims.

So, it's not about pointing

fingers. It's really about let's just identify the problems and come to some type of a solution for them working together.

And I appreciate your all's patience. I know that you all would like to have it done at the snap of a finger. It's been a difficult couple of months. We're still dealing with changes in the MCO contracts. You all are very much well aware of what's going on with that. So, it's taken us some time to get through all of this.

We also had a meeting scheduled with some folks from Texas on October 22nd but they had to cancel last minute and we're working to get that rescheduled.

The Department really just wants to talk to our counterparts there to figure out what are their lessons learned from the process that they implemented. We want to get their perspective from the agency side to help us understand what we may need to do to go to that, and we appreciated KPCA's recommended potential solution and we're more than happy to listen to that and to see if it's something that is feasible for the Department to do.

CHAIRMAN CAUDILL: Another thing in there, I appreciate what you said about the

massive dump of data. The element in here that also needs to be looked at is efficiency because being able to handle all the data that's generated through Medicaid is a tremendous task and whatever you all and us can work out that helps.

(ZOOM VIDEO CUTS OFF)

MS. CECIL: ----did not get that wrap. So, that's something we're able to automate. I'm kind of excited about that because I think anything where we can automate it definitely helps, but I did want to share that. That's one thing we already are starting to put into place to help resolve some of the issues.

CHAIRMAN CAUDILL: I know that KPCA is promoting the Texas plan and it certainly has a lot of advantage.

I would like to make a caveat that those providers that do OB/GYN service, labs and x-rays, the Texas plan would disadvantage in some ways and would ask that you all be cognizant of that in developing a model, trying to keep that from happening.

MS. CECIL: Absolutely. Thank you for that.

CHAIRMAN CAUDILL: Would anybody

else like to comment on this?

All right. Then, let's go to Item B.

MR. MARTIN: Chairman Caudill, I do have a question. So, Veronica, does Avesis that's under the dental claims bucketed in with that?

MS. CECIL: Stephanie, do you know for sure? I'm not 100% sure about that, Barry.

MS. BATES: I don't know if those were bucketed in or not. So, we'll check on that, Barry.

MR. MARTIN: Okay, because some that have dental, that's a pretty substantial amount.

MS. BATES: We'll definitely check on that. Thank you.

MR. MARTIN: And, Veronica, the way we talked about it is after you guys get with the MCOs and try to collect all their data, because what I understood is you've asked them to give Medicaid everything. Whether it was paid or not paid or if it's a denied claim or if it's a zero pay, everything is to be dumped into DMS for review, right?

MS. CECIL: That's correct, Barry.

MR. MARTIN: Okay. And, then,

you're going to get with us after you review that to see where some of the pitfalls are at with the MCOs processing the claims over to DMS and, then, kind of get with us to see where we're having the pitfalls as well, right?

MS. CECIL: That's correct, Barry.

MR. MARTIN: I just wanted to be clear because based on our conversation, it seems like we're on the right path; and if we can continue that, I think we will come to a resolution and figure out.

Just based on our conversation, we've had instances where you've already found out, based on some of this MCO data, of some of our pitfalls and that's encouraging.

MS. AGAN: Mike, I have a couple of questions. So, I heard us raise the issue about Avesis. Would these claims also include our behavioral health through Beacon and any other third party?

MS. BATES: We'll check on all of the subcontractors.

MS. AGAN: And when you said that they sent everything, what was the time frame of

everything? How far back does that go?

MS. CECIL: You know, Yvonne, we didn't look at specific dates. What we did was they took them all in and then arranged them according to error code. So, I apologize but we didn't pay too much attention to how far that went back or the subcontractors.

What we were most concerned with is trying to just look through what were the reason codes and trying to figure out what the problems were, not necessarily - we did not necessarily get into the weeds in our conversation.

After each IT meeting with the MCOs, we have asked them to go back and look at each one and provide us a little more detail about it because we do plan to take that back and look at that a little more deeper. So, that's where we were with that.

MS. AGAN: So, what I think I'm understanding is that this data that was sent in is really more of a sampling.

MS. CECIL: The request to the MCOs was to send everything.

MS. AGAN: But we don't know if that goes back to July 1st of 2014.

MS. BATES: So, if they didn't send it, then, they should send it. And, so, that includes, if they didn't send something, all the way back to those dates.

MS. AGAN: Do you all have any goals of time frames for what you're working on to complete this process?

MS. CECIL: The time frame is kind of driven by the work. Like I said, we've got two MCOs tomorrow and, then, one more MCO to go and I think it's next week or the week after.

We'll probably need about two weeks to pull all that information together and put it in a somewhat understandable format so that we can reach out to you all, KPCA and a couple of the providers because I know several providers have shown interest in being part of that conversation.

So, I think we're looking - I'd like to say we're looking towards early to mid-December to have a good understanding of what the issues are, working with providers, developing solutions so that we know where we are kind of going forward.

And, then, with the Texas model, we're just trying to find out if that's the

best course. I really can't tell you anything in terms of that.

MS. AGAN: Well, thank you for sharing all of this. I think it all sounds very positive at this point.

DR. MULLINS: Mike, it's Raynor. I just want to echo Barry's comment and thank him for raising the issue of the dental claims. That's been an ongoing issue, I think, and frequently dental gets left out because there is a subcontract with Avesis and a couple of other folks.

So, I would just urge you to make sure that that's included in this process, but this whole discussion sounds very positive from someone that's been in it a bit from the beginning. And thank you, Veronica, for your efforts on that, and hopefully this can all get moved to a more positive place.

CHAIRMAN CAUDILL: I think between your statement and Barry's statement, that certainly the Department is on notice that it is an issue and hopefully we can address that as part of it in the future.

There not being any other comments----

MS. AGAN: Just one more quickly and I'll try to be quick. Can you explain the process of how you're going to match this data up, what's coming in from the MCOs, what the clinics submitted? Is it going to be a match between the clinics and MCOs and DMS or are you even far enough along to even answer that?

MS. CECIL: I honestly believe that we'll probably have to do that for a sample of the claims to really understand what's going on. So, I think that's definitely on the table.

MS. AGAN: Okay. Thank you.

CHAIRMAN CAUDILL: Anything else, Yvonne?

MS. AGAN: No. Thank you all.

CHAIRMAN CAUDILL: Thank you for your comments and questions. Anyone else to add anything or have any questions or whatever?

Hearing none, then, let's move to 4B which has been on here before and we're requesting an update on the G2025 telehealth codes not being recognized and it concerned with effective date of 7/1/20. This differs from the latest CMS letter.

And, like I said, this was on

the last one, too, so, we're asking for an update. In looking over the old minutes, I saw where Humana from last meeting had said that they had the G2025 telehealth code loaded with the July 1, 2020 effective date.

And I also saw where Yvonne had asked and Charles Douglass agreed to check on and report back about whether that would cause a problem when those pass through as crossover secondary claims to Medicaid. Is Mr. Douglass on this meeting?

MS. BATES: I don't think so. Lee, can you speak to that?

MS. GUICE: We have checked on that and we don't believe that there's any issue with the crossover claims.

MS. AGAN: That would be good, and thank you for checking on it just to make sure.

MS. GUICE: So, if you run across one, make sure you send me the specific example, okay?

MS. AGAN: Okay.

CHAIRMAN CAUDILL: Is there any further report that the Department would like to make on the status of this?

MS. AGAN: So, the question that

we originally asked, and help me understand if I'm misstating this, was the concern that the G2025 was only going to go back to July 1st and if some of the clinics submitted that claim prior to July 1st.

So, Lee, are you saying if they submitted that claim prior to July 1st as they were told to do, that that would go through to DMS okay? Am I understanding that correctly?

MS. GUICE: Who told you to submit it prior to 7/1?

MS. AGAN: It's in the MLN Newsletter. We talked about that at the last meeting.

MS. GUICE: Okay.

MS. AGAN: I personally am not seeing rejections. There was just a concern, especially I think the rural health clinics were advised to use that code.

MS. GUICE: I'm looking at our MMIS page right now and the code is in here, and I believe our effective date would cover anything prior to 7/1.

MS. AGAN: Okay, but I just want you to know that Medicaid did tell us we could use that before July 1st.

MS. GUICE: Yes. CMS added the code in January.

CHAIRMAN CAUDILL: Is anyone having any particular problems with this code not being recognized or anything?

MS. AGAN: I can't say that there is. It was just another question.

MS. WEIKEL: This is Michelle Weikel at Humana. The MCOs were communicated a 7/1 effective date. So, that's what we loaded in our claims system.

So, if DMS is indicating that the effective date should go back to January to align with CMS, we're going to need something from DMS that advises us of the revised effective date.

MS. BATES: We'll go back and look and see what was sent out to MCOs versus what the system will pay; and if we need to update that, we will. We'll give you an update here in the next week or so if that works.

MR. HARILSON: This is Noel, if I may. Stephanie, thank you. Thanks, Michelle. That was really what the question boiled down to is we had been made aware that the MCOs had been given that 7/1 effective date. So, we were concerned if

any claim came to the MCO, it would be denied on the front end before it ever made it to Medicaid for any sort of look at. So, that's really what it boiled down to on the original ask.

MS. BATES: If you ever have a question like that, just come out of the gate with it and we'll resolve it, but we'll check on it and get back with you.

CHAIRMAN CAUDILL: Okay. So, let's leave this on the agenda for one more time and find out the status in our January meeting.

MS. GUICE: Okay, but just to be clear, nobody is experiencing any denials. Is that right?

MS. KEYSER: Not at this time.

CHAIRMAN CAUDILL: No, not at this time.

MS. AGAN: We don't think so.

MR. MARTIN: Not that I know of either.

CHAIRMAN CAUDILL: Then, let's move to 4C which is also on the previous one - DMS limitation of thirty sites' NPI.

From the minutes last time, and this is an issue that Yvonne had brought to our

attention, but from the minutes last time, Lee Guice stated that Provider Enrollment sent confirmation that Medicare does not care nor does MMIS care but for some reason Partner Portal seems to have that limitation. Ms. Guice stated that DMS is in discussion right now looking to see what the effort would be to increase that number and to move forward with increasing that number.

So, Lee, you've already spoke up, so, I know you're here today. Would you care to address that?

MS. GUICE: I can address it if you'd like.

MS. HUGHES: I'm sorry, Lee. I think Carl sent Veronica some information on it and I don't think you were copied. So, if you want her----

MS. GUICE: It's okay, Sharley. I was getting ready to talk to Veronica but thank you.

MS. CECIL: Okay. I'll take that. We have put in a change order to increase the number from thirty. We have to put some limit in there. So, we are going to limit at a hundred.

I cannot imagine a provider would reach a hundred, but if a provider ever has any

issue, they should reach out to us and we'll take another look.

And if you're going to ask what the effective date is, I'm not sure that was included - I could try to find that; but, again, if there is a provider that is having an immediate need, definitely reach out to me or Kate Hackett in Provider Enrollment and we'll continue to work with you.

CHAIRMAN CAUDILL: So, as I understand it, that you are in the process of getting that changed to a hundred; and if for some reason that is not adequate for a particular provider, then, they will contact you directly and you'll work with them.

MS. CECIL: That's correct, Mike.

CHAIRMAN CAUDILL: Okay. I think that resolves that at this time. Does that satisfy you, Yvonne?

MS. AGAN: Yes, it does. Thank you all.

CHAIRMAN CAUDILL: So, that's the end of Old Business and we can, then, move on to New Business at this time. The first item is 5A, no-show screen on Kyhealth.net.

Beth Partin as Chair of the MAC and Commissioner Lee had discussed this during the September MAC meeting. The Primary Care Technical Advisory Committee would ask for further detail on how this would work and what tracking can be done.

MS. GUICE: This is Lee again. We are beginning the process of gathering the information and submitting the correct change order to add this screen to Kyhealth.net.

What we're looking at just at a really high level right now is for the provider to be able to go on to Kyhealth.net just like you would check eligibility. So, you would pull up the member and there would be a place to enter a code that says this member had an appointment and they didn't show up for it, pretty basically. It's just a tracking mechanism.

CHAIRMAN CAUDILL: Okay. Let me ask this, then. Could that system be expanded to include non-engaged patients so that they can be tracked and perhaps DMS intervene to assist us with getting a response and being able to follow up with those patients?

MS. GUICE: I would say that for managed care-enrolled members, the managed care is

supposed to be managing their membership in that way. So, if they're not engaged, Im assuming that you should reach out to their managed care and ask for them to assist with reaching out and having them get engaged.

CHAIRMAN CAUDILL: Actually, a lot of times, managed care reaches out to us because they're unable to get a patient engaged and we're unable to, also, but in some cases, we are.

But, still, there are non-engaged patients out there that neither of us has much luck and was wondering if this is an area that DMS could assist in in the future. I mean, we're all wanting these patients to be engaged and work on their problems and be able to fill any care gaps.

So, whatever we can bring to bear on that would have a good result for everybody was the nature of why I was interested in that question anyway.

MS. GUICE: Well, that's a larger question, Mike, that we have not discussed but certainly we can take that back or you can make a recommendation to the MAC on that.

As far as I know, this screen that we're talking about, the no-show screen is just

for individuals who have an appointment and they don't show up and it's to track that specific item so that we will have some data on that instead of anecdotal discussions about it.

CHAIRMAN CAUDILL: Okay.

MS. GUICE: And I'm not saying that maybe that data wouldn't be something that could be shared with managed care in the future to say this member is clearly missing appointments. We haven't discussed what we're going to do with that data as much as we have discussed how to collect it.

CHAIRMAN CAUDILL: All right. Let's go to New Business B - RHC/FQHCs remaining distant site for telehealth services in Kentucky after the pandemic health emergency.

At this time, is there any consideration about this becoming permanent? It has shown itself to be very important during this pandemic and has allowed us to work to protect the safety of patients and the medically-underserved communities which we serve.

It has allowed our patients to be able to access primary care and behavioral health services while physically distancing themselves and, thereby, helping to prevent the spread of COVID-19.

And once this is under control, we still will have needs of these patients that have significant barriers like transportation which this, unfortunately, affects patients of lower income and those living in rural areas, to continue it.

Allowing permanent distant site services for FQHCs and RHCs will reduce the barriers to health care access and provide sustainable reimbursement for telehealth services provided by FQHCs and RHCs. And, again, it will allow us to better serve our patients and reduce care gaps and be able to focus more on the quality efforts.

It has been very productive for us and for our patients. I know specifically like our patients being discharged, instead of them coming in to the clinic for a followup, we're able to do it by telehealth and prevent them from having to go through transportation barriers and perhaps even presenting themselves in an environment in weakened condition that may be not the best environment for a person in that position to be in.

So, maybe I'm kind of going around the bush on this, but the bottom line is, is there any discussion about making the telehealth services, a distant site, a permanent fixture when

the pandemic ends or goes away?

MS. BATES: Mike, I just wanted to let you all know that, of course, we've obviously been talking a lot about telehealth and how good everything has gone since the pandemic hit and telehealth has really progressed pretty quickly and we're pretty happy with how things have been.

We were already pretty expanded before, but I think what we're seeing really is more providers are using telehealth. I know that your provider types were doing a little bit more before. So, the pandemic has kind of pushed other providers that were apprehensive to go ahead and do that. So, that's good.

And we're taking any recommendations on any kind of expansion of what we do cover outside on the other side of this. So, I would urge you to get with your group there, and if you want to make a recommendation, that's where you need to go just so that way we have all of that.

We have obviously received recommendations from other groups as well, and our intent, I believe, is to make services available for everybody as much as we can. So, we're not opposed to you all recommending that as a TAC for sure.

CHAIRMAN CAUDILL: Just for your information, we do about 20,000 encounters a month, and of those, roughly half will be Medicaid. And what we have found is that with the March and April onset of the pandemic, we went up to 60% of our encounters was through telehealth, and now that's more moderated. We run about 25% on a daily basis of our encounters will be telehealth.

Anyone else like to address this?

MS. KEYSER: Mike, this is Chris. Again, I think it's a great thing, and what has been beneficial for us, again, as you said, is just making more options available to our patients, particularly those who feel that if they have health conditions, they don't want to get out. It gives options to the provider, options to the patient.

But to think that there could be a time on it to where this would be cut off, this option will be cut off, I think going forward, that's the part that I think we need to consider as a recommendation to the MAC is that it just makes good sense to allow this to continue as an option, not that we're all going to go 100% telehealth, but that from time to time, there will be people for whatever

reason - you mentioned discharge, visits and things like that - where people just don't want to get out like maybe they did before.

And, so, this is a real option. And instead of having it kind of be it's turned off for a while and, then, it takes a pandemic to turn it back on.

So, I think that there is real legitimacy to this committee making a recommendation to the MAC for a permanent option to allow us and RHCs to have telehealth be available all the time, again, at our discretion.

CHAIRMAN CAUDILL: Thank you, Chris.

MS. AGAN: Mike, I would support both what you and Chris have said and the concern that it could be shut off and how that would affect the care to these patients. So, I think the recommendation to try to keep it going without interruption would be very important.

MR. MARTIN: This is Barry. I also think there's a telehealth steering committee and other subcommittees that are meeting and giving recommendations to Medicaid and DMS that is in sequence with the same mind set.

CHAIRMAN CAUDILL: Okay. Anyone else? The next issue is related to potential payment processes that could affect FQHCs/RHCs, the duplicate logic 5001 encounters, and I believe Teresa Cooper from KPCA, Director of Policy, would like to expand on this.

MS. COOPER: Thank you, Chairman Caudill. We would just like some clarification on an issue that has been brought to our attention about an edit for duplicate logic. The edit number is 5001 for encounter data that should go into effect January 1st that will penalize MCOs for any duplicate encounters.

And as we understand it, the logic includes same clinic NPI, same member ID, same date of service, and same procedure code. And we would just like to know, what is the purpose of this because this could adversely affect many of our visits that are conducted within the FQHC or rural health clinic and, then, could possibly carry over to DMS and adversely affect the supplement payments that you have to pay out to us and increase those on your behalf.

MS. GUICE: Lisa, this is Lee. Can I ask a question?

MS. COOPER: Yes, ma'am.

MS. GUICE: What is it about that edit that would impact - that would not - how is that not just a regular duplicate claim edit?

MS. COOPER: Well, say you have a patient that goes in to see Dr. Smith and they're diagnosed with pre-diabetes or diabetes and that clinic happens to have an endocrinologist on staff that has an opening that day that can see that patient and Dr. Smith codes that visit as a 99213.

They go over and see the endocrinologist, Dr. Jones. Dr. Jones does his work-up and also codes that as a 99213 and that comes in on the claim because the way that the edit reads is it is not only looking for two separate claims, but it's looking at the same claim for two different line items with the same CPT code.

MS. GUICE: Wouldn't you have two different rendering providers on the claim?

MS. COOPER: Well, the rendering ID is not part of the logic that has been brought to our attention, and that was what we were asking for clarification on. If that's there, if it could be put there, because it could be a potential that it could kick out one line that would pay maybe $25 at a

PPS rate that was $100. Each of those 99213's would pay a total of $50, and if you're kicking one out, that is taking it down to $25 which is actually increasing the supplemental payment that DMS would need to pay.

So, we're just looking for clarification, and if the rendering NPI is not part of that logic, could it be placed in there?

MS. GUICE: Okay. Thanks.

MS. AGAN: I think another clarification that we're asking for is, so, if you had the scenario that Teresa just went through, that if MCOs are not supposed to submit the second visit to DMS, just that clarification because if they're not submitting that second visit with the endocrinologist, how is DMS going to get that clinical data in their system on the treatment of, in this case, this example of that diabetic patient?

I would think DMS would want to see all of our activities and all of our services rendered to any given patient on any given day.

MS. GUICE: I will have to take a look at this edit and we'll have to do some further research on it. It wouldn't be my understanding that we don't want all of the clinical data. So, I'm not

sure what it is that you've been told by the MCOs. We'll have to take a look and see how it's working and get back with you on that.

MS. COOPER: Thanks, Lee. That's basically all we were asking is that you look at it and see how it might potentially affect any data that you would receive or supplemental payment that would need to be made to the facility.

MS. AGAN: And we ask for clarification to make sure we understand the edits.

CHAIRMAN CAUDILL: Any other questions or comments?

Then, we'll go to the updates or announcements from the MCOs. Do we have any MCOs that are in attendance today?

MS. WEIKEL: This is Michelle Weikel from Humana. I think the only announcement we would have is that I believe everybody has been communicated that Humana's plan name will be Humana Healthy Horizons effective 1/1 of '21. So, there's a lot of materials out in the market that share that brand name, but, otherwise, I don't know that I have any further announcements for the group.

CHAIRMAN CAUDILL: Anyone from Passport or Molina?

MS. AGAN: I have a question for Michelle. In the process of rebranding this name, will you be sending out new ID cards? Will the members' ID numbers change or will they remain the same?

MS. WEIKEL: They will get new ID cards that show the new logo but their ID numbers will not change. And it does not affect your underlying provider contract, right. The Humana provider contracts remain the same. It's just the change of the plan name.

CHAIRMAN CAUDILL: Anybody from Passport or Molina? How about WellCare?

MR. AKERS: One update. On our biweekly WellCare informational webex that we do every other Friday, coming up, next Friday, we're going to use that forum to conduct a virtual provider summit. We did that earlier because of the public health emergency.

So, on Friday, the 13th, we are going to conduct a virtual provider summit in that format and we're going to be sharing just a lot of updated information on provider resources, value-added member benefits and other information that we believe will be beneficial to providers. So, if you

don’t have that invite, let me know and I can send that over to you. Thank you so much.

MR. HARILSON: Mike, if you don’t mind, Christine Drake is trying to get off of mute for Passport as well.

MS. DRAKE: Good morning, everyone. This is Christine Drake with Passport Health by Molina, and I would like to provide updates, that we are getting excited for our acquisition and transition on 1/1/2021.

You guys should have received the recent E-News yesterday. We have a lot of upcoming provider orientation sessions and we encourage everyone to sign up for one of those. We have lots of information and moving parts on that and we definitely look forward to continuing our partnership.

CHAIRMAN CAUDILL: How about Aetna? Am I missing anyone, any other MCOs that I’ve not mentioned?

MS. SMITH: This is Jennifer with Anthem. So, I just have a couple of updates. I just wanted to let you guys know that we are hosting a provider webinar next week. We have two dates that are being held next week. It will cover all lines of

business. So, hopefully you can join. It will be Tuesday, November 10th at 10:00 and, then, Thursday, November 12th at 2:00. So, I just wanted to let you guys know about that.

We also have sent out a notification for our members advising of the open enrollment for the 2021 Plan coverage.

CHAIRMAN CAUDILL: Thank you, Jennifer. How about United?

MS. BOWLIN: So, Aetna is on the line and no new announcements from us today.

CHAIRMAN CAUDILL: Okay.

MS. BATES: Mike, do you mind if I say something?

CHAIRMAN CAUDILL: No. Please go ahead.

MS. BATES: I just wanted to put a plug in for open enrollment. Open enrollment started on Monday, on the 2nd, and it goes through December 15th. And I just sent Sharley - you'll be getting some materials that we are asking everyone to share.

Open enrollment materials getting into members' hands was delayed this year. So, we're trying to lean on all of our partners to

put that information out. So, when you receive that, just anybody that can share that, that would be really helpful.

CHAIRMAN CAUDILL: A very good point, Stephanie.

Does anyone else have any announcements that they would like to make along the same lines?

Then, we will go to recommendations to the MAC under E. Certainly, I would suggest that the committee recommends that the Kentucky Department of Medicaid Services work to allow FQHCs and RHCs to act and bill as a distant site for telehealth services post the public health emergency that's currently going on.

Would anyone like to make a motion to make that recommendation to the MAC?

MS. KEYSER: Mike, this is Chris Keyser. I would.

CHAIRMAN CAUDILL: And would anyone like to second that?

MS. AGAN: I'll second it.

CHAIRMAN CAUDILL: All those in favor, please say aye. All those opposed, like sign. Motion carries.

Are there any other recommendations to be made for the MAC at this time? By silence, I'm assuming there's not.

The other item of business is scheduling meetings for the next calendar year. Currently, we are meeting the first Thursday of every other month beginning with January. Does this meet with everyone? Would you like to consider an alternate date or is everybody happy with this?

If we do go with this, the meetings will be January 7th, March 4th, May 6th, July 1st, September 2nd and November 4th for this upcoming year. Anyone like to comment or have any thoughts on that?

MS. AGAN: I'm okay with the first Thursday of every other month.

MS. KEYSER: That's good for me, too.

DR. MULLINS: I'm good.

MR. MARTIN: I'm good with the schedule.

CHAIRMAN CAUDILL: And I am also.

MS. HUGHES: Mike, I think I sent out that a couple are scheduling them as a Zoom

meeting rather than an in-person meeting and it will not be considered a special meeting because you're actually scheduling it at these meetings. So, you're not going to be restricted to whatever is on the agenda.

CHAIRMAN CAUDILL: Yes, and you sent that to me in an email. Thank you so much for doing that. So, therefore, we have more flexibility as it will be a scheduled rather than a special meeting.

MR. HARILSON: Do you want to keep the same time at 10:00, 10 to 12:30?

CHAIRMAN CAUDILL: It works well for me. Everybody agrees.

The Chair would entertain a motion that for 2021, that we would meet through Zoom meetings beginning in January and continued every other month for the first Thursday of the month from the hours of 10 a.m. to 12:30 p.m.

MR. MARTIN: I'll make that motion.

MS. KEYSER: I'll second.

CHAIRMAN CAUDILL: Any discussion? All those in favor, please indicate approval by the sign of aye. That's unanimous.

So we now know what the next meeting is for not only January but the rest of 2021.

Before adjournment, is there any business that anyone would like to bring forth or comment be made at this time?

There being no such matters brought forward, we are ready for adjournment, and a motion for adjournment, please.

MS. AGAN: I move that we adjourn.

MR. MARTIN: Second.

CHAIRMAN CAUDILL: All those in favor, say aye.

MEETING ADJOURNED