CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID
PRIMARY CARE
TECHNICAL ADVISORY COMMITTEE MEETING

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Via Videoconference
October 24, 2024
Commencing at 10:02 a.m.

Shana W. Spencer, RPR, CRR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Stephanie Moore, Chair

Brandon Harley

Dennis Fouch

Barry Martin

Patrick Merritt

P R O C E E D I N G S

CHAIR MOORE: So I'll go ahead and call this meeting to order. Good morning, everyone.

And this is our last TAC meeting with our current slate. We have a -- Barry Martin has been elected as the new chair for the Kentucky Primary Care Association, and we'll be establishing a new TAC committee.

So Brandon is here. Barry is here. I don't see Dennis. Dennis hasn't joined; correct?

MS. LEWI: I see Dennis.

MS. BICKERS: I believe he was logging in a -- he was just now coming in, so he may just be getting into the meeting.

CHAIR MOORE: Good morning, Dennis.

So I think that that establishes our quorum. So moving on to the approval of the minutes. Is there a motion to approve the minutes that were emailed?

MR. MARTIN: So moved. This is Barry.

CHAIR MOORE: Thanks, Barry. Is there a second?

MR. HARLEY: Second. This is Brandon.

CHAIR MOORE: Thank you, Brandon. All in favor, aye.

(Aye.)

CHAIR MOORE: Thank you. So moving on to old business, if Veronica is going to be a few minutes late, should we defer that piece?

MS. BICKERS: Yes, if you don't mind.

CHAIR MOORE: Sure. Okay. So we'll skip down. Is the DPH representative on this morning?

MS. BICKERS: I don't believe we were able to get someone this morning, so I apologize on that.

CHAIR MOORE: Perfect. And what about DBHDID?

MS. BICKERS: Give me just a moment to scroll. I apologize. I'm not seeing anyone logged in currently. I know several people did accept the invitation, but I can keep an eye out for someone as they pop in.

CHAIR MOORE: Okay. Well, we'll

skip down to the PCA and updates from the PCA on the CIN, except that I'm also not seeing Dr. Houghland.

MS. LEWI: I'm here, Stephanie. Dr. Houghland is kind of juggling two different meetings, so I'm here.

CHAIR MOORE: Hey. Good morning, Molly.

MS. LEWI: Hi. How are you?

CHAIR MOORE: Good.

MS. LEWI: So do you want me to take this, Stephanie?

CHAIR MOORE: Yes, please.

MS. LEWI: Okay. Sure. So we were -- a couple of things. One is with respect to school-based clinics, it was -- the issue was raised and, you know, introduced last time about well-child visits and immunizations and then just different outreach and ways to deliver preventative and well care to children.

And we thought that it would be relevant to bring up and raise attention to the discussion that has started about school-based clinics. As you all know,

there's two different types of services. There's the school nurse feature from -- that has to do with the Department of Education and providing resources and accommodations for children in the school setting and with IEPs.

And then there's also the school-based health center, or the kind of more comprehensive health center model that is developed and offered either by a Federally Qualified Health Center or rural health clinic in a school setting.

And so there are -- several members of this TAC are offering those services, and they can share about how they're offered. But I think it's helpful to bring attention to the differences between those two types of services and what -- and how, you know, children who are on Medicaid are -- especially are being cared for or, like, kind of what the resources are and how they're coordinated. That's provider type 21 -- that is the school nurse provider type -- is different than what the school-based health center is able to do.

And so we would like to be able to be engaged in those conversations about what the opportunities are. We understand that it has a lot to -- of coordination is required between the local school and the community and just how the services are rendered and billed and the consent from the parents. But wanted to bring attention to the fact that a lot of those services are offered by the primary care providers that are represented through this TAC.

And then, Barry, would you like -- does anybody want to add to that?

(No response.)

MS. LEWI: And some of the hurdles that you all are encountering.

CHAIR MOORE: Sure, Molly. I'll jump in.

We have a school-based site at Berea Community, which is a K-12. We have behavioral health and a nurse there every day.

When we first started, we had staffed a nurse practitioner at that location in an attempt to have enough billable visits to

sustain the school-based model and, you know, sort of what we call those boo-boos and band-aids kind of visits that are nonreimbursable to Federally Qualified Health Centers and rural health clinics.

What we found was that the volume of that made it virtually impossible for her to also conduct billable visits. So we transitioned to staffing that with an RN and then linked to one of our existing clinics via telehealth if we need to do a billable visit. But we really discovered that we need to have sort of two pathways and two rooms going.

So this year, we're now -- we have kind of two exam rooms, if you will, so that we can do sort of the daily boo-boos and band-aids, you know, working with diabetic students to adjust their insulin after lunch and sort of those, like, nonreimbursable things. And then in the second exam room, if a child does need a billable visit, then that happens via telehealth in the other exam room.

Additionally, we have LCSWs working in

the school and then we have a mobile dental unit that goes to Berea Community regularly as well as another -- a number of other community -- schools in our community.

But I do think that, you know, the inability -- you know, the school doesn't have the bandwidth and the budget to hire the nurse, which is why they oftentimes look for a partner. But it's been our experience that it's really difficult to break even on a school-based clinic when you're doing all of this work that ties up your healthcare provider that's nonreimbursable.

So like I said, we're trying something different this year. But it, you know, very much is our concern that if we can't find a way to make that program more viable, that we will have to look at, you know, changing our model completely.

Dennis, Barry, Brandon, Patrick, John, I see you guys on there. Are any of you doing school-based health, and what's your model, in your experience?

MR. LILLYBRIDGE: We don't have school-based here.

MR. MARTIN: This is Barry. We've had it for about 12, 13 years. And we started out with the nurses in -- in the schools and then we kind of evolved to what we call an edu-health program where a nurse practitioner, or PA, is at the clinic, and the nurses correlate that with them whenever it triggers a visit caliber.

And so we kind of do the same thing, but a lot of the services -- I mean, and that's why the health departments had to get out of it, was because a lot of the services that they provide, it's been more and more born under the school nurse, and it's not a billable service, especially under RHC or FQHC rules. The nurse visit is not billable. So that does cause some problems, financial constraints.

MS. LEWI: Patrick, you're in schools; right?

MR. MERRITT: Yeah. Yes, I am. Can I ask a question, what we're talking -- I'm sorry. I've been on the road.

MS. LEWI: We were just discussing members of the TAC that offer school-based

health centers or are in relationship with the school nurse program and the balance of that. Because you all are a different provider type than that provider type 21 nurse that's able to bill in a different capacity and has a different scope.

MR. MERRITT: Right.

MS. LEWI: But the services that you're able to offer require a different layer of coordination with the school and also additional resources and professionals.

MR. MERRITT: Yep. Absolutely. So we've had school-based now for about four years. We were very lucky to accept school-based funding for the start of that, so we initially started up during COVID.

The majority of our visits initially, honestly, were collaborating with the schools and trying to figure out, you know, how to have that point-of-care testing, so we could get kiddos and the staff in the schools -- try to keep them healthy and work in conjunction with the schools.

We started out with utilizing MAs or LPNs in the schools in conjunction with

telehealth services with our providers inside of our main sites, and we were using telehealth options. Then we grew, and the services were utilized to a pretty great capacity.

So just pretty much initially, the first year, we were just acutes and COVID testing, but we were trying to transition that to primary care. So we staffed up and put in an NP, a dedicated NP inside of our schools. So we have one NP inside of five schools, and we have MAs in every school, too. That NP has the ability to rotate.

And one of the challenges we've had is really defining and working with the school system and having clarity on the separation of duties between what the schools do from a liability standpoint, the Kentucky Department of Education, and what our role is within the schools. It's definitely been a challenge.

But our school system had never had health care in the school systems up until we stepped in, so one of the biggest challenges for us was just creating that culture and making sure that we collaborate together.

From a billing standpoint, we're about 80 percent Medicaid inside of our school systems, so we've been able to be very -- pretty profitable up to this point and for -- and we see a decent amount of volume. But it doesn't take a tremendous amount of volume to break even, and we've always ran it as, like, a no-cost-to-the-school model.

CHAIR MOORE: Emily, I think that that's a great illustration because if you can really just provide the -- like, the actual visit services that the student needs and -- you know, that's really important because a lot of students, like, their families aren't able to get them to care, or they get them to inconsistent care. Or, you know, particularly, we see with oral health that they just go without.

That you don't have to have a lot of volume, and it's an important service in the school that I think we're all committed to. But if the school is also looking to you to do the day-to-day traditional school nurse pieces, it's really difficult to --

MR. MERRITT: Yep. Stephanie, can

I kind of piggyback on what you just said?

CHAIR MOORE: Yeah.

MR. MERRITT: Yeah. Stephanie is exactly right. So we actually worked with our school district to come up with a new contract for this school year, and what happened was we started tracking -- we call them "kid care touches."

It was how many times we touched kids for boo-boos and band-aids and ChapStick and sunscreen and just everything that you can imagine. And what we were seeing was 75 percent of our daily visits were based around nonbillable visits; okay?

And what we went to the school and told them is we want to stay in the schools. We want to be viable. But also, too, we live in a very impoverished community, and our schools honestly cannot afford to pay us to have health care in our school systems.

So it's, how do we advocate for our children and give them access to that care without, you know -- and from a liability standpoint, like, I can't afford to put an NP in every school, and I have to figure out how

to stretch resources as far as possible.

So one of the challenges for us was, all right. Well, here's what we know. Here's the needs and stuff like that. But what we noticed was the schools were passing a lot of stuff off to our girls inside of the school district and allowing them to do a lot of stuff that was really outside of their scope, of, like, handing out ChapStick and stuff that the front staff and, you know, other staff within the schools, the youth resource service center and stuff, were doing before we got there.

We'd just become kind of dump site. And they would just give us all these little things and ice packs, and we would do all this stuff. And it got to where it was interfering with us doing med dispensing or any of the basic necessities that the kids actually needed.

So yeah, Stephanie, I would agree a hundred percent. I think figuring out how to collaborate and have the schools do their fair share so that we can actually do the job that we need to do.

MR. MARTIN: Well, the problem is the schools don't have the financial resources to put nurses in themselves. The health departments used to do it but then I think their reimbursement kind of went away. And so there's nobody else to really do that except for us.

MS. LEWI: Yeah. And there's a real value to the parents, to the school system to be able to meet the students' needs there and be able to kind of triage and respond.

MR. MARTIN: Well, and overall, it helps attendance. It helps attendance with the kids.

MS. LEWI: Right.

MR. MARTIN: It helps attendance with the workers, the teachers and the staff. They also use the service, so it's so beneficial. Our superintendent would say that it would -- it's crucial to keep the service, but it's just -- it hinges on the backs of the healthcare providers, not actually the schools.

MS. LEWI: Yeah. So -- and then

also the needs -- the behavioral health needs of the students as well. Are you all providing behavioral health support as well?

CHAIR MOORE: We are.

MR. MERRITT: Molly, this is Patrick. We are not but for the sheer fact that we don't do dental or behavioral in the schools even though we offer behavioral at all of our other sites. They have a great relationship with Lifeskills, and they have a lot of staff that are on site daily. So we collaborate with them.

And then dental, the current health department has had a longstanding contract for about a decade with the school system and offer dental services.

CHAIR MOORE: One of the things that we saw was that some of that -- in our community, Patrick, the health department would do some of the hygiene, like apply fluoride and stuff like that. But, particularly, as students got older in middle school and high school, they needed dental treatment. So, you know --

MR. MERRITT: Sure.

CHAIR MOORE: -- we were getting calls from people who -- you know, I've got this 16-year-old who's trying to sit in Spanish class who -- their face is swollen, and they're in such pain. Can you get them in?

And so it has been wildly successful to take our mobile unit to the schools, and it's been really exciting to hear from students, to hear the students express how much they value that service.

We've been doing behavioral health since we started at Berea probably 10 or 12 years ago. And, again, it's a little bit of a different kind of dynamic but similar in the sense that what we've seen is that the school also -- they need somebody doing traditional therapy, but they also need somebody functioning more in that behavioral health consultant role, managing the crises that come up during the day.

So, you know, kids with various different behavioral health diagnoses have symptoms that disrupt classrooms, and so -- or they will want to -- the teacher will want

to consult with the LCSW to say, I have this student in my class. How can I best support them?

And so, you know, it would be really difficult sometimes because teachers would walk -- you know, want to walk in while she was in a session. And so we really had to do some reminders to say, you know, we're glad to provide some consultation, but that has to happen outside of our visits with kids because the kids are going to come first.

But yeah, Molly, I think that I could probably put five therapists in even just Berea, and they would stay busy.

MS. LEWI: So to summarize, I think that what has been said and the reason why this is on the agenda is because with Kentucky's -- with commitment to, you know, improving the health of children, schools are an awesome access point in terms of the fact that children go to school.

There's, you know, doors that are wide enough, you know, or ramps. There are interpreters. You don't have childcare concerns. There's buses, so transportation

isn't -- when children go to school, it's -- we're trending in the right direction.

And so -- and primary care providers are an important part of being able to care for children when they're at school and be able to help them stay in school.

And so as the Department for Medicaid Services and the Department for Public Health look at ways to coordinate programming to support the health of children, it would be -- we would like to invite or to request inclusion of those conversations.

Because what you all have been able to work at a local level in coordination with the school nurse as distinct and apart from or perhaps as a delegated -- or however the -- the arrangement seems to differ from one location to the other based on the -- kind of the community needs, that what is able to be provided in a school health clinic is of tremendous value.

And we would like to be able to be a part of the conversation of what's necessary in order to sustain that and improve, you know, the viability of that operation.

Because it sounds like you all have had to be pretty creative in how to make it work. But, at the same time, you're asked to come do it because the other entities haven't been able to make it work.

And so we're committed to this cause, but we think that with some coordination of resources and programs, we can, you know, be better stewards of public funding and the ways that the operations work.

CHAIR MOORE: Thank you, Molly. Are you going to talk about the TAC changes as well, or is Barry going to do that?

MS. LEWI: Barry, would you like to do that? So --

MR. MARTIN: Talk about what?

MS. LEWI: So I'll just tee it up.

MR. MARTIN: Okay.

MS. LEWI: I'll tee it up for a second; that, as you all know, by statute, we have the Primary Care TAC. The KPCA is able to facilitate this for them, and we really appreciate and are grateful for that opportunity. And it's something that our members really value.

And so it is something that our -- as a nonprofit, we have a Board of Directors that reflects our membership and then the TAC is an important part of being an advocate for the stakeholder group.

And so Barry we're excited to have as our incoming chair. Stephanie, we're so grateful for your work over the past two years. And so it's kind of -- at the end of this meeting, we'll have the passing of the torch for the TAC.

And Barry is working to construct the next group of five representatives. Barry?

MR. MARTIN: Yes. The next chair of the TAC will be John Lillybridge, and he's on the call. And Patrick will stay on there, and Dennis Fouch will be joining us. Brandon will be still staying on there and myself. And I think that's the group of five on the TAC for the upcoming --

MS. BICKERS: Barry, sorry. This is Erin. Do you mind to run that -- I've got John, you, Dennis, and Brandon. Did I miss --

MR. MARTIN: Patrick Merritt.

MS. BICKERS: Patrick. Thank you. Well, welcome, John and Patrick and everyone else staying. Stephanie, thank you very much. Barry, I may reach out to you just to confirm I have everyone's correct contact and email address after this meeting.

MR. MARTIN: Okay. Sounds good. I can send that to you.

CHAIR MOORE: Molly, are you also going to do the update from the CIN in Dr. Houghland's absence?

MS. LEWI: Happy to. So I think currently, our latest -- the last count I saw is that our CIN is covering -- has about a million -- I mean, I'm sorry, about a half-a-million lives, about 350,000 Medicaid lives covered through -- almost 90 of our members are able to collectively come together and coordinate services in order to work pursuant to the contracts that we have with all six MCOs, a couple commercial plans, and Medicare Advantage Plans.

Currently, we are working to work with our payer partners to reach those quality goals that were set by the Department for

Medicaid Services. And with the investment and implementation of a population health tool, we are seeing increases in the number of immunizations and well visits, the use of -- or kind of helping to work on pre-visit planning in order to do the preventative care services and are really thrilled with the data that's coming in and the work our members are able to do in terms of creating -- not only scheduling and creating access to their services but also being able to get those records, you know, in a way to the payer so that it's recognized which, as you all know, is more -- is harder to do than it seems.

So we are coming up on the end of the year and working together with the payers to kind of -- for the year-end or year-closing and then also looking ahead for the next year and are -- I'm not sure if Veronica was able to sign on, but we were interested in knowing more about what the quality measures and the quality plan will look like for Medicaid for next year.

CHAIR MOORE: Thank you. I think I

saw on the chat that Veronica has joined, so we can kind of jump back up. But I think, Angie, you had said you could kind of speak to that value-based program. So does that include also the measures for next year? And if so, maybe we can just transition to that piece now.

MS. PARKER: Sure. Yes. I would be the -- I am Angie Parker. I'm the Director of Quality and Population Health for the Department for Medicaid Services. The MCO value-based program, if you are not familiar with it, I do have a few slides on that if you'd like me to share.

CHAIR MOORE: I think most of us are familiar with it. But if there were changes for next year, then we would be glad to see those.

MS. PARKER: There are no changes for next year. It is an ongoing value-based purchasing program. As of right now, unless there are challenges or issues with the current HEDIS measures -- there might be some slight changes, but there are no changes at this point. Other than for 2024, HPV was

just report only, and it will be measured next year.

MS. LEWI: What about the social needs, Angie?

MS. PARKER: It will also be measured next year. It's a report only for this year. There's been -- and we understand there's been challenges in getting that data because of the providers not always billing via a Z code or the LOINC codes.

But we will be evaluating that. We won't -- obviously, we won't have 2024 data until next spring because, you know, you have the measurement year and the following year. And so we won't have all those results until later in 2025.

CHAIR MOORE: Do you know if there's been any sort of billing guidance given related to the LOINC codes for the social determinants? I know that, you know, we do social determinants screening on all patients annually. And we will add some of the diagnosis codes related to the food insecurity, but those are not LOINC codes.

And so we have been a little unclear if

it's an either/or or if, Emily, LOINC codes are included for that measure. And if so, is there any specific billing guidance around that?

MS. PARKER: I'll have to defer to Justin Dearinger who is in our Health Care Policy Division, the director of that, as far as billing. Obviously, we are -- I do believe the MCOs are working with providers, ensuring that these type SDoH codes are being billed when identified.

But, Justin, I don't know if you have any input regarding the LOINC codes at this point.

MR. DEARINGER: Not currently. We've got a group of those codes that we're looking at as far as reimbursement, and we've actually got a project going on right now where we're looking at all of those codes in general.

So we have a large listing or a lot of new codes that have come out this year. And so we have those with everything else that's on our fee schedule currently, and we're looking at how those codes are currently

being reimbursed by each MCO by fee-for-service, whether they're on our fee schedules or not.

In the same vein, we've also got a part of that project, which is reviewing other states and seeing how those codes are being paid or if they're being covered by their states and what the reimbursement rates are for those codes and how they're being utilized.

And then a separate piece of that is we've also got a group looking at private insurance throughout the United States and how they are utilizing those codes and functions and what percentage they're being reimbursed by. So it's all kind of a part of a bigger project that we're looking at.

So as a whole, I don't have a lot of information until that project is complete. That project should be complete, we're hoping, before Christmas. So that'll be done, put together in a -- kind of a presentation format in a decision memo.

But there will probably be four or five different ways we could go decision-wise with

the final results of that just based on the sheer number of those codes and which ones to add and what their reimbursement rates will be and how those are utilized. So we'll send that to leadership, and we should have answers and responses back on exactly how those are going to be utilized, how those are utilized now, all those different things, first part of 2025.

CHAIR MOORE: Okay. Thank you. I think that that's the key really for us, is when -- you know, if we're going to begin being measured on something, you know, on January 1st, then we need that early in the year so that we can get our IT infrastructure aligned to do that, so thank you.

MR. DEARINGER: And that will be a -- you know, that will be -- when I say that, I don't mean we're implementing something the first -- I mean, that -- where we're going to move with that will be -- should be ready toward the first part of the year. Providers will be given plenty of time to review that, give feedback, you know, get some information from our shared partners in

that.

MS. PARKER: I would say, regardless of how that goes as far as the review, the expectation would be for any provider, if these social determinants of health are identified, that they are billed -- I mean, not necessarily billed. But the diagnosis code should be there so that it helps us and you identify any areas that we need to focus on a little bit more and just to kind of get a better idea of how this is affecting the overall health with the social determinants of health.

So it's very beneficial for lots of different reasons to ensure that providers are billing this consistently and asking those questions.

MS. CECIL: Good morning. This is Veronica Judy-Cecil with Medicaid. Just to add a fine point to that, is -- Stephanie, thank you for kind of flagging that, and it makes total sense that providers need the information to, you know, be able to be part of the collaboration that's happening around this.

It is our expectation for Managed Care Organizations to do that, that communication around, you know -- especially around the metrics that they're going to be held accountable to -- you know, on working with providers on making sure that we're getting the data, the information, the claims that support that so that we can measure, properly measure so...

But a takeaway from here, we'll talk internally about, you know, what can the department do to bring especially consistency across the plans and education to providers and see what we can do more about educating the SDoH coverage.

CHAIR MOORE: I think that there have been times -- you know, currently, we're adding it just as a -- like I said, as a diagnosis to claims. I think that there have been times that plans have requested us log in to a separate portal to -- like, that is not feasible or sustainable or realistic, to ask a care team to double entry, particularly if you're using, like, a prepared survey instrument. That's not five questions. It's

a number of questions.

And so, you know, I think that we need to be mindful that we don't create additional burden for care teams when they're already pretty busy.

MS. PARKER: Agreed.

MS. CECIL: Yeah. That's a good takeaway. And, Angie, maybe, you know, we can talk to the MCOs about: How do we reduce the administrative burden?

CHAIR MOORE: So, Veronica, if you are ready, we will jump back up to old business. Any updates on PHE wind-down, redetermination, and wrap reconciliation?

MS. CECIL: Absolutely. I've just got a quick slide. I won't -- I won't take too much time for this, but let me share my screen just to give an update on the most recent renewals.

So just to let everybody know, we have come out of the Public Health Emergency unwinding for renewals. We've completed them all. So that first -- you know, we expanded it to 14 months. We took 14 months to process those renewals because we wanted to

make sure that our workforce could handle, the workers could handle not only the renewals but applications and other things that happen with the Department of Community Based Services for eligibility determination and redeterminations.

So we took 14 months, but we are now out of that unwinding period for renewals and have moved just right into kind of normal renewal processing. So you're going to see, you know, our flexibilities are still applicable that we've applied to the renewals, and that goes through June of 2025. CMS extended those for states, so we're going to take advantage of those, continue to take advantage of those.

But, you know, so we're -- you'll still see there extended population. Just a reminder, the extended population, those flexibilities are one month for anyone who didn't respond to a renewal notice. We can give them an additional month of eligibility and try to do additional outreach to get them to respond. And for long-term care and 1915C waiver members, they can get up to three

months' additional time to respond and maintain their eligibility.

So what you're looking at here is just the most recent months. Of course, we haven't completed October yet, so September is the last month that we've completed. We have 52,369 individuals who went through renewal. 45,833 of those were approved. That's a nice high number.

We're always happy to see, especially because we want to really prevent administrative terminations. They're called procedural terminations, where somebody didn't respond, and so we had no choice but to terminate them because they didn't respond. So in the termination bucket is 1,234.

The pending column is just a reminder for those folks that -- they came up on their renewal date, they actually responded, but the State didn't have an opportunity to process that. And so it was pending as it crossed over the renewal date. Those individuals maintain eligibility until the State processes the information.

And then extended from the September renewals is 5,301. So those are folks that are in either that one month, or they may be in somewhere starting their up to three months of extensions.

That last far right column, we're still tracking restatements. We'll continue to do that even though we've come out of the unwinding renewals, and so reinstatements for September are 189. Those are folks that we're tracking in that 90-day period following their termination. If they didn't respond to a notice, they can provide the information. We determine them eligible. We can reinstate them automatically up to 90 days back to their renewal.

That's important for providers to understand. So if somebody comes in, they just were terminated because they didn't know or didn't respond to an active renewal, that renewal notice requesting information. If they do that and they're eligible, we could cover those services and reinstate them.

So we're still reminding providers that, you know, if you have somebody come in and

they -- you can see that they're -- their redetermination date just passed, or they're within that 90-day period, encouraging them to contact us through Kynect. You know, we'd still like to make that determination. It's always better if we can determine somebody ineligible. Because, at that point, if they're ineligible for Medicaid, we might be able to connect them to a Qualified Health Plan.

So speaking of Qualified Health Plan -- sorry. Sorry about that. Just wanted to mention as we're talking about renewals, that the federal -- sorry. The state marketplace for Qualified Health Plans, Kynect, the Health Benefit Exchange, open enrollment is coming up November 1.

So Medicaid is a continuous open enrollment. If you're eligible, you're in. You can become eligible at any time. You can enroll at any time. The Qualified Health Plan is a little different. There is an actual open enrollment period, so it's only during that time you can change it, your plan, and maybe only enroll, especially if

you don't have a qualifying event that would allow you to enroll at a different time.

So open enrollment is really important for Qualified Health Plans, understanding that you need to -- it's the only time you can change your plan or maybe enroll. So just letting folks know that that's coming up.

We already posted a pre-screening tool on our website. So if you have folks coming in, they don't have coverage. They might not qualify for Medicaid. You know, if you could please encourage them to go out and seek other coverage. We're trying to keep our uninsured rate really low.

So I've got some other new information for you guys, but that kind of concludes the information I had for the renewals. Happy to take any questions.

CHAIR MOORE: There are no questions on redetermination, if there is any new information on wrap reconciliation.

MS. CECIL: So for -- Justin, are you prepared to give a little --

MR. DEARINGER: Sure. Yeah. We

don't have a lot new going on. As you all know, the wrap workgroup is still continuing their work. They're still meeting and going through issues and resolving issues. So I think it's going very well.

We sent out some -- a wrap FAQ, which I think will be very beneficial. We have -- we're working currently on dental crossover claims and getting those clarified, more clarification on that. Crossover claims, dual-eligible claims in general, more clarification and resolving issues on retroactive payments and recoupments and working on our bypass list.

And so I think, you know, in the interim of those meetings, we're getting a lot of that stuff taken care of and tweaked so that in our FAQ document and in our document that we send out to providers, that we can clarify any problems or issues.

And then with the wrap workgroup, it's something that's going to kind of be ongoing to where any one-offs that occur, we can take care of those as they come up. So I think -- so far, it's been very successful, and we're

taking care and resolving a lot of those problems and issues that providers have had.

MR. MARTIN: Yeah. Justin, I have to say that we're not experiencing as many problems as we were in the past. So it's definitely a breath of fresh air to have this kind of collaboration and teamwork to make sure that we head off these issues. I mean, I don't know if Dennis and Stephanie and John and Brandon, have you guys -- are your organizations experiencing any problems with, you know, the wraparound process?

MR. LILLYBRIDGE: We're not currently.

MR. HARLEY: Neither are we.

MR. MARTIN: I didn't want to jinx anything, but I just thought I'd ask.

MR. FOUCH: Yeah. Same here for us. We seem to be fairly smooth right now and kind of hold our breath so...

CHAIR MOORE: We do a lot of dental so, you know, some of those dental problems that are getting worked out are still impacting us, but it's definitely better.

You know, I still think the elephant in

the room is a lot of those older claims and, you know, I'm probably -- I'm not going to be on the TAC anymore. But, Barry, I'll probably send you regular emails to ask that we continue to keep that part of the conversation because I think that there are lots of older claims. And we have earned that wrap money, and there needs to be a process for us to receive that.

And I don't know that the process can be a one-by-one claim, you know, for nearly ten years' worth of backdate when there wasn't a process for us to do ongoing during that time. So I hope that that continues to be part of the conversation, and we come to a resolution that's fair for both the provider and DMS.

And, you know, certainly we want to find a resolution that is compliant with federal regulations as well, but we need to talk about what reality looks like.

MR. MARTIN: Veronica, I thought we have addressed that. Hasn't DMS addressed that for providers one on one?

MS. CECIL: So I think -- and,

Stephanie, we can work with you specifically. I think our advice or communication on that was that -- to work through the MCOs because the issue is that there is -- you know, the encounter did not come into our system, and we can't pay a wrap on something that's not in our system so...

But, Stephanie, that's where we want to come in on an individual provider level, that if you're having trouble working with the MCOs on that and trying to really identify and then reconcile that, you know, we're happy on a -- to try to assist with that. But you do have -- it has to go through the MCO for us to be able to pay the wrap on it.

MR. DEARINGER: And then just to kind of add just a little bit. When you said -- I do know it's difficult when I say on a one-on-one basis on some of the different things. But each provider is so different in some of those past claims of billing and their own contracts with the MCOs.

And so it's so individualized that we've been working a lot with different providers

on individualized cases and past claims and trying to get those resolved and rectified. And it does take a little more time, but it is specialized. Each individual provider has that -- you know, those unique differences that we do have to look on it that way, kind of as a case-by-case basis.

MR. MARTIN: Okay. Because I did think what we left this as is, you know, we would get things streamlined from a certain point forward. Once we got that streamline, then people like Stephanie that's having individual problems, if they're showing that the MCOs or what they've done with the MCOs are not clear and not going through, that that's when you guys would step in and kind of help with the process.

So, I mean, definitely, we've talked about this. We can't help from an overall standpoint from that angle, but we -- but there is a process in place for each organization to work through the MCOs, then come to DMS for assistance; right?

MS. CECIL: Yep. That's correct.

MR. MARTIN: Okay.

MS. CECIL: Yes. And, Stephanie, happy to continue to work through your specific case and please share that with providers. I mean, if there are other providers that have past claims that they're struggling going through the MCO and trying to work through the MCO, that they definitely should reach out to us.

MR. MARTIN: Molly, maybe we can send that out from an organizational standpoint.

MS. CECIL: Yeah. And I'll post again the email address that, you know, we really prefer providers to work through so that -- because that email box is -- several staff have access to that, so we can make sure that those things are being addressed and responded to.

MS. BICKERS: Veronica, if you'd like, in our follow-up email, we can add that along with the dispute forms.

MS. CECIL: Yeah. That would be great.

MR. MARTIN: Okay. Thanks. Once again, thanks to DMS for helping us get this

lined out from this point on as well.

MS. BICKERS: Stephanie, you're muted.

CHAIR MOORE: So I guess, then, moving on to new business, we talked about the value-based program. Were there any updates on the utilization trends?

MS. CECIL: Angie, do you have -- were you looking at that?

MS. PARKER: I guess my question is: What specifically are you wanting to know about utilization trends? Are you wanting to know what we're seeing as far as cost and utilization?

CHAIR MOORE: I think that -- and Dr. Houghland had led a good part of this conversation previously. But, you know, who is using services, what services are being utilized, you know, who was not using their services, and where are they, all of those kinds of things.

Are people only utilizing, you know, what -- I would be interested in, you know, how many members are only using emergent care and are not, you know, seeking primary care.

Those, you know, sorts of trends that we can collaborate on to, you know, get people into the settings of care that we want them to.

MS. PARKER: It would be very helpful if you could supply us a specific list of what you wanted to look at, and we can certainly pull those reports and report on it.

CHAIR MOORE: Okay.

MS. PARKER: If you want to send that to Erin and then we can look at -- what you want to specifically address and then we can -- we do have lots of reports and, you know, we just want to make sure that we are addressing what you are wanting to see and hear.

CHAIR MOORE: Molly, can you please share that with Dr. Houghland? Because I know that he had sort of had a list that we had talked about over time.

MS. LEWI: Yes.

MS. PARKER: We had provided some information a while ago, and there was some clarification on some areas that we needed to get some additional information. We need

to -- it needs to be pretty specific on what you're requesting so that we can make sure that we are able, No. 1, to gather what you are wanting or needing and then address that. More than happy to pull that information for you.

MR. MARTIN: You know, Molly had mentioned earlier that, you know, we're really pressing DMS and MCOs and -- the providers are really pressing the need for well-child checks and immunizations and other quality measures for our patient population.

I want to impress on the MCOs and DMS to help us with these incentives, the incentive programs that the MCOs offer. Those are very hard for the patients to access. It doesn't make sense in offering them if you can't access it.

MS. PARKER: Like the value -- like, getting an incentive to get their immunization or coming in for a well-child visit, yes.

MR. MARTIN: Yes. There has to be an easier process or more streamlined, more patient-friendly process. There's nothing

patient friendly about it.

MS. PARKER: We've identified that there are some challenges in persons being able to access those rewards. Obviously, it's also an onus on the MCOs for them to be able to get -- because they are being measured on it as well.

MR. MARTIN: Right. I just want to keep it at the forefront.

MS. PARKER: We can certainly, obviously, address that and see if there's been any improvements in that.

MS. LEWI: I agree, Barry. As you are saying it, we would be interested in knowing how -- from the MCOs, like, utilization of those value-adds and maybe starting the conversation of how to rethink that. It takes a lot of work and effort from a health center to help connect their patient with the value-add that, you know, is achieved through the service.

And it also, to be honest, creates some equity issues when the child whose parents, you know, and with the assistance of the provider, end up with the Nike shoes because

they got their vaccine. And then the kid at school is like: How did you get those new shoes? And they're like: Well, I get WellCare. They're like: Well, I have Acme, and I -- my mom got a car seat. You know, like, I want shoes, too.

So it just creates a lot of confusion and a little -- with having so many MCOs, not only does it take a tremendous amount of effort in order to access the value-add, but the variety of products, it creates a lot of confusion in what is available to each patient and then also just kind of exponentially increases the amount of work so that the CHW, or whoever is at the clinic helping them to access it, you know, to know all of the different ones.

So we would encourage some consideration of creating easier access and also some more standardization so that they can be more effective and more known.

MS. PARKER: We do have a value-add side by side. Are you familiar with that? A side by side of each MCO and what value-added benefits that they offer, and we are actually

updating that for 2025 now.

MS. LEWI: And, actually, if you -- I think that that side by side really highlights the fact that they are all very different, and that's six different portals or apps that have to be accessed in order to get it. So I think that is exactly what we're talking about.

It's also what the connectors use in helping a -- somebody who is eligible for Medicaid in deciding which plan to go with. Those are kind of -- those are available to them and how they are decided upon.

But circumstances change. People's plans change. There's lots of churn. And I think if you asked how many of those car seats, tennis shoes, gas cards are actually accessed, we would be surprised at the number.

MS. PARKER: We do have that information. Just FYI, we do get reports on the value-added benefits.

MS. LEWI: If you could share that next time, it would be really helpful next time for that to be shared. What is the

process to access it? How cumbersome is it, and how often are those by MCO accessed?

CHAIR MOORE: Angie --

DR. THERIOT: I'll throw this out there. Oh, I'm sorry.

CHAIR MOORE: As you update that side-by-side sheet, one of the things that makes it much more practical in clinic that we had our -- one of our managers do was go back and create a column on the left to have rows by benefit. So that, like, here is the row for well-child visits. Here is the row for benefits to pregnant mothers. Here's the row to, you know, benefits related to diabetics, related to weight loss or food insecurity or whatever.

Because it's -- to Molly's point, it's such a variable list. And, you know, it looks really great. Oh, you can get a Weight Watchers membership with this MCO, but it's actually only for this tiny subpopulation. So that ended up making -- like, that additional layer of detail made it much more practical for use in clinic. So just a suggestion as you update it for '24.

MS. PARKER: Noted. We'll try to make it easier, but it is -- it is a challenge when you -- to your point, for the example you used, if they're only eligible for Weight Watchers for a certain thing, part of that is to drive that person to kind of look on their website to see what all that involves. It is challenging to put, you know, even on two pieces of paper, to have that side by side to give all the details of what those value-added benefits are about. But I understand the challenge with that and might be able to help with that a little bit more.

DR. THERIOT: What about different side by sides? Like, have one for well-child and then have a separate one for maternity, you know, a third one for disease-specific. I know that's different pieces of paper. But, still, it's all the information you need for that one person to look at. I don't know.

CHAIR MOORE: Yeah. I think that that even would be more helpful because then you can give it to the appropriate team, you

know. The pediatric team doesn't necessarily need to know the maternal health benefit because, likely, that mom has already aged out of that benefit.

MS. PARKER: It might be of a benefit to have each MCO discuss what their value-added benefits are and how they can access at this meeting, for you to get it directly from them.

I mean, I certainly do not mind supplying -- I can give you the report on what we are receiving on the utilization of the value-added benefits. But I think it might be better to come directly from the MCOs on what their value-added benefit program is, how it's set up, how it's used, and potentially address the access issue with them specifically.

I mean, we can assist with that, too, but I think it might be helpful for you all to hear that from them as well. We can address some of this on the back end of things but just to kind of hear more about what their value-added benefit program is like. That's -- obviously, that's up to you

all. That's just as a suggestion.

CHAIR MOORE: I think that we had done that at one of the meetings earlier this year or late last year. But, you know, I think for all of the MCOs on the call, you know, any sort of alignment that they can create with each other, you know, would certainly be, you know, valuable from our perspective in terms of supporting patients and utilizing those benefits.

MS. PARKER: Okay.

CHAIR MOORE: We didn't have anybody from DPH. Is there a DBHDID update?

MS. BICKERS: I did not see someone join. I will make sure, as we set the 2025 calendar dates, that they are aware. They may just have had a conflict and did not reach out.

CHAIR MOORE: So I think, by my assessment, we've covered all of the items under old business or new business. Is there any other business from committee members today?

Veronica, I think that you said you had a slide about some changes to the MAC that

you wanted to review.

MS. CECIL: Yeah, if that's okay.

CHAIR MOORE: Absolutely.

MS. CECIL: I don't want to keep people too long, but I think it's good information. Let me -- Erin, let me share. Let's see here.

Just a couple of things, and we're trying to talk more about this. You're probably going to hear us talk a lot more about it as we move into 2025, and that is the -- there were a bunch of federal rules that came out over kind of the last six months to a year that impact Medicaid.

And so we have been -- this is the list of nine. I'm not going to go into every one of these just to let you kind of -- again, we're just trying to let folks know what's happening and that there will be some changes on the horizon.

They have varying deadlines. In fact, just a few have taken effect, but they don't really impact this work or providers directly. Most start next year. They go all the way up until 2030. So, you know, there's

quite a length of time that will happen for some of these.

We are identifying currently the requirements for each and the impact to the Medicaid program, in particular each provider. You know, they may impact provider types differently depending on the requirement. So we're going to be presenting more and more as we do that identification and development of our implementation plan.

We really want folks to be at the table with us. This is not us, you know, just deciding everything and then implementing. We really want input from providers, from members, from advocates on how we move forward in this.

But the one I really wanted to talk about was there are some changes -- and these are actually effective July next year. So we've been starting to work on this, and it relates to the Medicaid Advisory Council and the creation of a new Beneficiary Advisory Council. So some states already have what's called a BAC, a Beneficiary Advisory Council, but the federal law now requires every state

to have one.

And then the final rule changes also impact the makeup of the Medicaid Advisory Committee. So Kentucky will need to make some changes to comply. We're talking about this, though -- what's important to understand is that, you know, each state is a little different. There are base requirements that every state has to comply with and then states can make -- have some discretion; for example, the additional composition of the MAC.

And so, you know, we'll have some decisions that are Kentucky specific that we'll need to make. But our MAC and our TACs are in state statute. And so in order to be compliant, we really need to be thinking about: What are the changes to those statutory requirements at the state that will put us in compliance with the federal law?

They really -- I think the goal of this was to bring some consistency across the states in how they handle their Medicaid Advisory Committee and then the creation of the Beneficiary Advisory Council, so there

will be some consistency still across the states.

I'm not going to go into this a whole lot. We'll share these slides with you all. But this just sort of talks about what -- those sort of minimum requirements that the states are going to have to make. On the left side are the MAC changes, and on the right side are the new Beneficiary Advisory Council that we're going to have to work on.

All of this, again, is just making sure that the MAC and the TACs understand that we've got a lot of work to do and changes that are going to have to happen that are going to require the Medicaid agency to do a lot of work.

And so in thinking through our structure and how other states are structured, right now, what we're trying -- we've brought on a consultant to help us with this because there's no way we could implement nine different final rules without some assistance.

So we have a consultant on board right now that is reviewing the requirements, the

federal requirements, looking at other states and their structures, and then, you know, provide some recommendations about what Kentucky can do. What is kind of the recommended best course for Kentucky?

We can't do that without your all's input, though. Please understand that. We -- this isn't about us creating something and telling you what it's going to be. We really will be seeking your all's feedback. And I think what we're asking is just to please -- you know, as we engage you on this process, is to really think about what's best for Kentucky and our structure.

We're going to be looking at things like agenda items that cross multiple TACs, you know, trying to reduce maybe some duplication. You know, what are the areas that, really, we need to be at the table and discussing, and is there a different way to approach it?

So -- but the really kind of important thing to understand about the MAC is that starting in July next year, 10 percent of the MAC has to be members that are on the BAC.

So we have to -- we have to get the BAC membership up and running and then 10 percent of those have to be on the MAC.

So when you're talking about our current MAC structure and how many members we have on our current MAC, you're talking about bringing on a required minimum of 10 percent by July next year. You know, I think we just have to think about: For Kentucky, what does the overall MAC look like and the representatives that are on it and, you know, what kind of changes are going to be necessary for that?

The other kind of, I think, really impactful thing here are the terms and the ability to serve consecutively. So the federal law is very clear that you can only have one term, and the term length can be determined by the state. So that's something we'll be discussing with you all.

But members can't serve consecutively beyond that. So, you know, where we have had a lot of members on our MAC serve lots of consecutive terms, this is going to be a major change for us. And when you think

about having to have memberships across 17 TACs and then also have membership on the MAC, again, is where we really need to talk about our structure and what works best for Kentucky.

Because finding enough providers willing to participate, finding enough members willing to participate -- because we have members that serve on several of the TACs as well. You know, we have to really think about what our resource limitations are when it comes to the number of people that are eligible or even interested in serving.

We will have to start submitting an annual report to CMS about the MAC activities. And, you know, already we have a recommendation process. So that's something we'll have to report to CMS, too, about recommendations that come from the advisory committees and how the Medicaid state agencies responded to those.

You know, I think where we want to move to is just making this as collaborative as possible. We want providers and members to feel like they're engaging, and they're being

listened to and that we are taking the recommendations into consideration. And so to do that, you know, again, just may mean that we might have to sort of change the structure that we currently have today.

And so, you know, again, the thing here -- sorry. Let me go back. Kind of the roadmap that we're seeking right now is we've been doing a gap analysis. Our consultant is looking at best practices across the state -- across the states nationally, and then we're -- we plan a lot of engagement with you all, with the rest of the TAC members, with the MAC members, with members, with providers in general.

So we're going to be doing a lot of just sort of surveys, or we might hold town halls or something just to get some engagement around a discussion of what it's going to look like for Kentucky.

We do have to do a state plan amendment for this. And so we, again, have to kind of, in the next couple of months, probably three to four months, really figure out what is Kentucky 's structure going to look like and

then -- so we can move through the process of getting everything set up.

We are concerned about trying to be in compliance by July next year, especially for a state that doesn't already have a Beneficiary Advisory Council. So it's going to be a very heavy lift for us. So just kind of wanted to put it on your all's horizon, letting you know what's going on and just hoping that, you know, we have really great conversations. It's going to mean change, and so we have to acknowledge that and be willing to work through that together.

CHAIR MOORE: Thank you for that update. I feel like we should apologize for the work that that creates for your team or at least extend sympathy.

All right. Is there any other business from other committee members?

(No response.)

CHAIR MOORE: All right. Hearing none, are there any recommendations for the MAC out of this meeting today?

MR. MARTIN: I don't think I've heard of any other than just reminders.

CHAIR MOORE: All right. Well --

MS. BICKERS: Stephanie?

CHAIR MOORE: Yes, Erin.

MS. BICKERS: I'm sorry. I did want to let you know, at the last meeting, I believe Barry had requested that the MCOs provide the primary care provider change forms. We've got those all gathered up, and we'll get them out to the TAC. And we will also send them to our new members so that they have them. If you want to review them, any questions, we can add that to the agenda next month or reach out to your rep or myself if you have questions.

And I also wanted to mention I am working on the 2025 meeting dates and hope to have those out within the next week or so for approval.

CHAIR MOORE: Great, Erin. Thank you.

If there's no further business, is there a motion to adjourn the meeting?

MR. MARTIN: So moved.

CHAIR MOORE: Thank you, Barry.

MR. HARLEY: Second.

CHAIR MOORE: Thank you, Brandon. All in favor?

(Aye.)

CHAIR MOORE: All right. Thank you all for your time this morning.

(Meeting concluded at 11:10 a.m.)

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C E R T I F I C A T E

I, SHANA SPENCER, Certified Realtime Reporter and Registered Professional Reporter, do hereby certify that the foregoing typewritten pages are a true and accurate transcript of the proceedings to the best of my ability.

I further certify that I am not employed by, related to, nor of counsel for any of the parties herein, nor otherwise interested in the outcome of this action.

Dated this 5th day of November, 2024.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR