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

IN RE: PRIMARY CARE TAC MEETING

March 5, 2020
10:00 A.M.
Kentucky Primary Care Association
651 Comanche Trail
Frankfort, Kentucky

APPEARANCES

L.M. (Mike) Caudill
PRESIDING

Raynor Mullins
Yvonne Agan
Barry Martin
Chris Keyser
(appearing via video)
TAC MEMBER PRESENT

Mary Elam
Noel Harilson
Teresa Cooper
John Inman
David Bolt
Rachel FitzGerald
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Steve Bechtel
Sharley Hughes
Lee Guice
Candace Crawford
MEDICAID SERVICES

Pat Russell
WELLCARE

Christine Drake
PASSPORT

Cathy Stephens
Michelle Werkel
Bethany Day
HUMANA

Sammie Asher
JoAnn Rose
Lisa Lucchese
AETNA BETTER HEALTH

Ken Groves
ANTHEM

John Teichman
UNITED HEALTHCARE

Teresa Dotson
MOUNTAIN COMPREHENSIVE
HEALTH CORPORATION

Stephanie Wilson
Darryl Wilson
BARBOURVILLE FAMILY HEALTH

AGENDA

1. Call to Order

2. Establishment of Quorum

3. Review and Approval of January 20, 2020 Meeting Transcript and Minutes

4. OLD BUSINESS:
   A. Report on wrap/crossover claims cleanup July 1, 2014 to June 30, 2018
   B. UB Modifier is not working as intended - Update requested from DMS on current change order. What is estimated completion date?
   C. Adding G0511 to the DMS fee schedule - Update requested from DMS on current change order. What is estimated completion date?
   D. 340-B Pharmacy Policy and Procedure Manual (Promulgation) - Update requested from DMS regarding details provided by KPCA
   E. Targeted case managerst

5. NEW BUSINESS
   A. PCTAC representation at MAC meeting 3/26/20
   B. 2020 Updated Fee Schedule - any updates from DMS?
   C. Health Risk Assessments completed by MCOs - What is being done with the reports from MCO to DMS? Can we get access to the HRAs for the patients being seen in our clinics?
   D. DMS limitation of 30 site NPIs - Can DMS have someone who can speak to this policy attend?
   E. MCOs reimbursing colorectal screening at age 45 and following KRS 304.17A-257 for testing options?
   F. Updates or announcements from the MCOs
   G. New items for discussion
   H. Recommendations to the MAC

6. Adjournment

MR. CAUDILL: If it pleases everybody, we will call our meeting to order and we need to establish the existence of a quorum.

MR. HARILSON: We have a quorum.

MR. CAUDILL: I'm here. I'm Mike Caudill. I'm Chair of the committee. Chris Keyser, she is with us electronically. Barry Martin is on his way. He's not here at this time. Yvonne Agan is present and Raynor Mullins is present. So, we have a quorum.

Before we start, this is the first time we've had a meeting in this forum here. So, I will allow Noel to give you a little housekeeping.

MR. HARILSON: Sure. So, welcome to the offices of the Kentucky Primary Care Association. If you all need, there are restrooms back in the break room there. There's a restroom over here in this corner, and, then, there's one right behind the TV screen behind that wall.

I also want to let you know that the little tower you see on the middle of that table is both a speaker, a microphone and our 360-degree camera. It is voice-activated. So, just know that. When you speak, it's going to turn. So, we

try to keep it from where everybody is speaking over each other because as you speak, that's going to turn so the folks who are dialed in for video conference will be able to see you. Per the regulation, they have to see us and we have to see them.

And Sharley usually always mentions, if you can, for reporting purposes, make sure to try to remember to state your name before you speak so the court reporter knows and can put that in the transcript as well.

MR. CAUDILL: To help the court reporter, I would like for everybody to introduce themselves at this time.

(INTRODUCTIONS)

MR. CAUDILL: On to Old Business, then, under Topic A, the report on the wrap/crossover claims.

MR. HARILSON: Did you want to do the minutes?

MR. CAUDILL: I did. I did. I got ahead of myself. I apologize.

The meeting transcript was sent out and I'm assuming everyone has had time to read over it. Are there any modifications or changes that need to be brought to our attention?

There being none, is there a motion to approve the transcript as had been sent out?

DR. MULLINS: So moved.

MR. CAUDILL: By Raynor Mullins. Is there a second to that?

MS. AGAN: I second.

MR. CAUDILL: By Yvonne Agan. All those in favor, say aye. All those opposed. No opposition. Motion to approve the meeting transcript has passed.

Now let me go to Old Business. Under A, the report on wrap/crossover claims cleanup July 1, 2014 to June 30, 2018.

I believe that Mr. Bolt has had a meeting with Commissioner Lee and her staff this week and would like to speak to that.

MR. BOLT: To back up, we actually had a meeting with Acting Secretary Friedlander in January. As soon as Commissioner Lee was appointed, we had a meeting fairly soon after that date, and our latest meeting was March 3rd with targeted discussion points on the non-reconciliation/reconciliation - Steve and I fight over it - and Steve was at both of those meetings

with the Commissioner.

At this point, we are looking at the options with four clinics on providing more or less a proof of concept which is really back to the future with us. It's something that we've been talking about since 2014, but we have assurance from the Commissioner, I think with Steve in the lead to really move forward on capturing the data.

We're trying to look at some unique ways of lessening the problem with clinics. We've asked for a data dump where we could provide that to the clinics or within KPCA's capability to try to match things up.

We're trying at this point to figure out a way to create the least havoc we can with the clinics but it's going to hinge on what our three or four clinics in the proof-of-concept group show we can do.

I will point out that we are operating under a Tolling Agreement with the Cabinet, with DMS specifically. We have announced that we will not extend that. We want to see positive action between now and the first of May. When is the next meeting of this group?

MR. HARILSON: May 7th.

MR. BOLT: Steve may have something to add.

MR. BECHTEL: Well, I'll just talk so I can see the technology work.

I will just say this. I know a lot of the clinics who are here and represented here, I understand your frustrations. I'm just going to be honest with you. I share in your frustrations in this process.

Some of you that have worked with me understand that I'm talking from my heart right now, that I am frustrated just as much as you guys are with this whole process. So, we are committed to making sure to figure this problem out, the issues.

One of the things - I'll just be as honest as I can be, which I wish Barry was here. He was on the Transition Team when the Transition Team came, and the very first thing I mentioned to the new Administration was this issue and that this issue needed to be resolved, that it's been going on for many years.

So, I just want to let you know it hasn't been forgotten, even though you feel probably forgotten, but it hasn't been forgotten.

It's just been challenging in trying to figure out the processes.

We want to work together with you guys to try to figure out the issue and that's my commitment to you all. It always has been my commitment to you all. I can't tell you that there weren't some challenges from the previous Administration not allowing me to do that, but this Administration is very supportive of trying to figure out this issue. So, I just want to be as transparent as possible there.

We did meet, like David said, on Tuesday specifically about this issue and we understand the Tolling Agreement of June 30th but we were trying to show that we are trying to go in the right direction and give you some good faith there.

I'm willing to take any questions. I understand spreadsheets, you all don't like the big spreadsheets. So, we're trying to figure out how to do a data dump where we can get data. Of course, there's going to be challenges with that as well.

I hate to ask for more patience because I feel like you've already been patient enough and I feel like asking that is kind of a slap

in your face but give us a little time. We're going to figure this out.

MR. BOLT: Another part of the conversation with the movement forward with any new MCOs, for clarification, that the MCOs paying the PPS rate is considered by federal regulation - John, correct me if I'm wrong - it is an alternative payment methodology and requires the acquiescence of each of the clinics to participate which I think solves a problem.

Some other things that we talked about and there was agreement is some access to some different codes that we've learned over the last few years that would enhance the ability of primary care - and not just our clinics but primary care in general - in moving the needle on quality and cost, things like CCM which we have in place but doing targeted case management, peer support, things of that nature.

And, again, they were very, very open to that, as have most of the MCOs that we have talked with in the contracting process where we did the LOI's.

So, it's kind of moving in the right direction. We've just got to get out of first

gear and get into second or third or fourth here pretty soon.

MR. CAUDILL: Any other questions or comments?

All right. Under Item B is UB modifier is not working as intended and asking for an update from DMS. At the last meeting, Lee Guice spoke to this and said that she had sent an email to DXC, reference status, but she had only sent it that day.

MS. HUGHES: B and C, I think both, Lee is working on. And speaking of Lee, here she is. I was going to say could you hold off on those because I knew she was coming.

MS. GUICE: Sorry about that.

MR. CAUDILL: Good morning, Lee.

MS. GUICE: Good morning.

MR. CAUDILL: We're talking about the UB modifier and, then, we'll follow up with the G0511.

MR. HARILSON: I do believe that's the same work order, if I remember correctly, Lee.

MR. CAUDILL: And you were the person that spoke to those at the January 2nd

meeting.

MS. GUICE: So, the UB modifier was implemented on January 7th. So, it's in production.

I had to get somebody to look at my notes on the agenda that I left at work because I had another early meeting this morning. I apologize for that.

The G0511 I believe was implemented - and apparently I didn't turn that language read on my agenda, so, the fellow who read it to me didn't pick that up - but it has been implemented into production either at the end of January or the middle of February. So, it should be working.

MS. AGAN: So, we should see those things come through on the claims?

MS. GUICE: Yes. Right. It should be working.

MS. KEYSER: Mike, this is Chris. I have a question. So, again, just to clarify, if we have claims from January 7th forward where we're not seeing the UB modifier work again as it is intended as to be the notification that we should not get a wrap payment for a nursing visit,

how should those be handled?

MS. GUICE: Well, if you can send an example to us, if you can send the ICN so that we can take a look at it or send the paper claim, then, we can trace it back through the system and look at it if it's fee-for-service.

So, if you sent the claim through, it's paid, we've got the transaction, it's rolled through the wrap system and you got a wrap on it, if you will send us all of the information, all of the ICNs on those things, then, we can run back through the system and see what the issue is.

MS. KEYSER: And who are we sending it to? Will it be you or someone else?

MS. GUICE: You can send it directly to me.

MS. KEYSER: Okay. So, Mike, can we get that information sent out from the committee to members that if they are having some problems. Yvonne, are you seeing that working on your side?

MS. AGAN: I haven't heard any recent feedback but this has been pretty recent. So, I'm going to have to check with my crew to see if it's actually working now, but it's going back and

correcting any of the past that we have.

MS. ELAM: I can say that it's not working with several of the MCOs.

MS. GUICE: What do you mean it's not working with the MCOs?

MS. ELAM: That it's not implemented. A couple of the MCOs here I believe do need the original change order implementation from I believe 2018 when we initially requested this for 99490 and 99211.

MS. GUICE: I'm not sure I understand what the MCOs would need to do.

MS. ELAM: So, they need it to be able to accept the UB modifier.

MS. GUICE: So, they're denying your claims?

MS. ELAM: They are not paying the claim, yes, correct, per the fee schedule. I can't recall. There are two that definitely have that issue.

MR. HARILSON: Is Aetna one of those?

MS. ELAM: Aetna and Passport.

MR. HARILSON: That was asking for the implementation date.

MS. ASHER: Yes, and currently we are denying the claims back for invalid modifier until we get that system update.

MS. GUICE: When do you think it's going to be done?

MS. ASHER: We can put it in. I'll get that escalated as soon as possible. Hopefully - I'm not going to give an ETA - but I would like to see it within thirty days.

MS. GUICE: When you find an ETA, when you find out one because I know you don't get to go in there and enter the information - I'm aware of that - I don't get to either.

MS. ASHER: I'll let you know the ETA when I get one.

MS. GUICE: Okay. Thank you.

MS. DRAKE: The same thing with Passport. We will have to take this back and communicate that to you.

MS. GUICE: So, if you all hear something in here, you still don't do it until we give you the official communication, correct, would that be correct, through our actual regular----

MS. ASHER: Through our process, yes. Usually when it trickles down from the State,

we then update the system, but at this point, we have not gotten any communication.

MS. GUICE: Okay.

MR. CAUDILL: Now, it's my understanding that's supposed to be retroactive back to July 1 of 2019.

MS. GUICE: What you were told about the retroactivity, and, unfortunately, I didn't look up, but I would say that if you were told that, then, that's what the system will do.

MR. CAUDILL: Actually you told us that in the last meeting.

MS. GUICE: Okay. Great. Then, it was written down for me and I told you that.

MR. CAUDILL: Okay.

MS. GUICE: Thank you. I'm sorry. I've slept since then. I forget those minor details.

MR. CAUDILL: There you go. So, are there any more questions or concerns on that?

Okay. Then, we will go to D.

MR. HARILSON: I do have a question. Lee, based on what we just heard that the MCOs are waiting for the information to come from the State, would that list of "G" codes that was provided

that was part of that change order, that full list, will that be part of something that is actually I believe in New Business with any fee schedule updates or will that be a separate communication for them to be able to configure their system to recognize all of those "G" codes?

MS. GUICE: What I have to do is to, unfortunately, I'm not the actual person that notifies the MCOs.

So, we have a process in place for that and I don't have information on how that process was implemented for the UB modifier, much less anything else. So, I'll have to send off a couple of messages and find out.

MR. HARILSON: Sure, because you did say that they were on the same change order, if I remember that correctly. So, if that's the case, hopefully that communication would go together to the MCOs.

MS. GUICE: Right, hopefully.

MR. CAUDILL: All right. Item D is 340-B Pharmacy Policy and Procedure Manual - sometimes I have a problem saying that. So, you can read that word.

MR. HARILSON: Promulgation.

MR. CAUDILL: Yes, update requested from DMS. At the last meeting, Acting Commissioner Bates had said that our request for a legal opinion would be done and come back because the question was raised by Prentice Harvey about whether it had to go through the procedure under the administrative regs, and Commissioner Bates said that she was going to seek a legal opinion at our request that she does so.

MS. HUGHES: And I will apologize first. When I saw the 340-B, I went to Jessin and he wasn't going to be able to be here but he said he didn't have any kind of an update on the 340-B.

And, then, now I realize it was actually the letter that you all had sent from your attorney originally to Commissioner Steckel and then you re-sent it to Stephanie.

She has been in meetings and I have not been able to get an update from her, but I will get with her and see if she has found out anything.

MR. HARILSON: If the committee would like, I would just request maybe a written update prior to the May meeting on that that we can

share with the committee.

MS. AGAN: Yes. That's what I was getting ready to say.

MS. HUGHES: I can send her a text message and see if she gets back to me.

MR. HARILSON: Well, I mean, that would be fine, too, but----

MR. CAUDILL: We're coming up on an April 1 implementation date. So, we really do need that answered.

MS. HUGHES: Okay. I'll be happy to do that.

MR. CAUDILL: Commissioner Bates had said at the last meeting, I'll find out really quick and let you know.

MS. HUGHES: And there's one TAC that actually reads the minutes.

MS. GUICE: Government really quick is not reality really quick.

MR. CAUDILL: Okay. One thing that does not appear under Old Business but was discussed is about targeted case managers under the administrative regs is not specifically approved for FQHCs and that was brought to the attention and I think that also was presented to the MAC committee

which adopted it, and Commissioner Bates had said that this procedure would be put into place to get that changed. Is there any update on that?

MS. GUICE: So, usually----

MR. HARILSON: It wasn't on the agenda, Sharley.

MS. GUICE: Usually for MAC recommendations, we respond back to the MAC, don't we, if they sent it to us?

MS. HUGHES: Yes, and we would copy the Chair.

MS. GUICE: Right. So, if you haven't gotten anything on it, then, we haven't prepared a response for the MAC.

MR. CAUDILL: Okay.

MS. GUICE: Does that make sense?

MR. CAUDILL: It does. I'm just going on what Commissioner Bates said at the time of the last meeting that that would be done.

So, do we have any type of a time frame, then?

MS. HUGHES: No. And I'm sorry because it wasn't on the agenda and I didn't ask for an update. So, I apologize.

MR. CAUDILL: You're absolutely right and I apologize but I wanted to bring that up and not let it slip between the cracks.

MS. HUGHES: I will also when I get back try to get an update on that.

MR. CAUDILL: Okay. Thank you.

MR. INMAN: Mike, just a quick comment. We did have a conversation with Ann Hollen about the regs and she did say they would be opening those up to make some changes soon and they would consider what we were asking as far as those changes.

MR. BOLT: Supply your name.

MR. INMAN: John Inman, Kentucky Primary Care Association.

MR. CAUDILL: Is there anything else that should be addressed under Old Business before we move to New Business?

There being none, then, let's move to New Business and start out with Item A and the PCTAC representation for MAC meeting coming up on 3/26.

I will be able to attend that as Chair, and I apologize for having said that last time and then backed out because of a conflict that arose, but I've got it on my calendar this time. So,

I will do that one.

MS. HUGHES: Remember, since we're talking about the MAC meeting, it's held in our CHFS Building in Conference Room A and B in Public Health because we couldn't get the Capitol because of the Session. Oh, it's on there. I'm sorry.

MR. CAUDILL: It's on there. We'll to to Item B, the 2020 updated fee schedule, and we would like to know whether or not there will be any update or changes to the 2020 fee schedule, and if so, what's the status of that occurring?

MS. GUICE: The physician's fee schedule has been added, it was posted sometime this week and implemented in the MMIS at the end of February, so, just recently, 2/28.

The rest of them are coming in the process. As far as implementation, I know that we just have the physical therapy, those therapies, the fee schedule just crossed my desk earlier this week to be posted, and I think they should be implemented the next release which I don't have the date on.

So, are there change? There's always changes.

MR. CAUDILL: I was being kind.

MS. GUICE: There are always changes but nothing - just whatever the CPT codes and HCPCS code changes were.

MS. AGAN: Will that be retro to January 1 or from the implementation going forward?

MS. GUICE: Go forward.

MS. COOPER: And along the same lines as the change orders, when will the MCOs implement the fee schedule?

MS. GUICE: I don't know. When do the MCOs implement the fee schedule? When we post it, when MMIS does it, what?

MS. COOPER: Is there a notification that has to come from DMS?

MS. ASHER: Once we receive the fee schedule, we usually use the date that you list effective. So, if it's 1/1, it's going to be 1/1 in our system. So, we don't use the go forward. We use the retro.

MR. HARILSON: Teresa, are you asking more about the time frame that the MCOs have to configure their system?

MS. COOPER: Well, along the same lines as the change order, they weren't aware that there was a change order that had been

implemented. Do they have to wait for a communication or do they just see it posted on the website?

MS. GUICE: We have a process for that. I'm not involved in that process. So, I can't tell you for sure that it has been completed because I'm not involved in it; but if I could say, I would assume that on our fee schedule process, there's many other people involved in getting that together and posting it and putting it out.

So, I'm going to assume that it has been done, notification to the MCOs. And hearing nothing, we'll make that assumption and go forward.

MS. HUGHES: Mike, I did get a message back from Stephanie on the legal opinion and she has sent it but she has not received anything back from Legal yet.

MR. CAUDILL: Okay. Great. Thank you. Any other questions or comments about the updated fee schedules?

All right. Let's go on to Item C, Health Risk Assessments completed by the MCOs. We're inquiring about basically whether the HRAs for the patients can be seen by our clinics, the MCOs and Medicaid, between them, and we think that it would be

a useful tool to help us in achieving our quality measures.

MS. HUGHES: I did send an email to Angie and Stephanie. We are working on - it's going to be a summary - it's not going to be individual member data - that we will be able to look at to possibly help us drive quality decisions based upon the responses.

I don't know. The MCOs would probably be the best to ask if they could - my personal thought would be that that could be a HIPAA problem but that would have to be the MCOs to answer that as far as an actual PCC getting their patients' HRS.

MR. CAUDILL: Usually, then, what they come back with is, well, you've got to talk with the Department about that or the Cabinet about that.

So, it would be nice if we could get some coordination or a discussion where we can all be a part of that so that we can work out any issues like that.

MS. HUGHES: I will continue working with them.

MR. BOLT: A little more in

depth and we raised this issue with the Commissioner with the utility of the Health Risk Assessment and potentially expanding that to include information on social determinants of health.

If that's viable, I think we need to look at that because what we understand now is you all try to collect it. Where does it go? Is it a CMS mandate or a DMS mandate? What's its utility?

So, I think the real question that needs to be answered is can we make it a useful tool in driving information back to the clinics. And as far as sharing, KPCA holds the contracts for ninety clinics. There's no problem there.

We get the PHI on everything, more than I even want to think about, but getting that to the practices, maybe even considering a better way because we know that the MCOs' penetration rate is rather low.

Is there some way that that could be approached differently to capture more data that would be useful to the clinics and not just engaging the patients but dealing with the social determinants of health affecting their lives? Just kind of an idea.

MR. CAUDILL: Any of you people here from the MCOs like to comment on that?

MS. WERKEL: This is Michelle Werkel from Humana. I know the HRAs our clinical team uses in order to identify patients that potentially need case management needs, that kind of thing, I'm not sure about sharing it with the clinics. That's something that we can certainly take away.

I'm not so much concerned about a PHI issue because they're your patients. So, that wouldn't be the one that would give me pause.

But to be honest, in Humana's system, I don't know where those things live. It's more of the operational concerns, the logistics that would be concerning for me, and, then, certainly if there's any kind of obligation from DMS to advise the MCOs as to what's appropriate. So, that's what I think off the top of my head.

MR. CAUDILL: So, you would be willing to have a meeting just focused on that issue to discuss it and see what the limitations are and what the benefits could be?

MS. WERKEL: Sure, and determine what kind of options, what alternatives are

available, whether it's getting actual forms or some kind of data from forms, that kind of thing. I think that that makes a lot of sense.

MR. CAUDILL: What about the other MCOs in attendance? Does that go for you all also?

MR. GROVES: This is Ken Groves with Anthem. So, we have an application in our system called Patient 360 where that information is housed. The clinics, they have access to that. They can access and view the HRA.

And the second piece of that is that information is also gathered from the members and we use that data for case management.

So, therefore, any KPCA clinics, they can access the HRA. All they have to do is basically get access to Patient 360 and they can see that data.

MR. CAUDILL: Okay. Maybe the KPCA can facilitate that.

MS. HUGHES: Do any of the MCOs know approximately how many HRAs are being completed?

MS. WERKEL: From a Humana perspective, I don't know.

MR. GROVES: Ken Groves again. I

don't know off the top of my head but I can find that information out.

MS. GUICE: They do report that.

MR. BOLT: About 30%, I think.

MR. CAUDILL: All right. Any other discussion about the Health Risk Assessments?

There being none, let's move on to Item D, DMS limitation of thirty site NPIs, and Ms. Agan would like to speak on that.

MS. AGAN: Yes. We are requesting that DMS expand the number of NPIs that can be linked to a group NPI. Right now it is limited to thirty and we have sites that have more satellite clinics than thirty. So, they can't put their individual NPIs for their satellites on their roster.

MS. HUGHES: Per the response back when I sent this out for information, the limit is not a DMS limit. It is the NPPES NPI Registry limit which that's not a DMS thing, right?

MS. GUICE: No.

MS. HUGHES: So, that's not something that we would be able to increase. That's something out of our control.

MS. AGAN: Then, I would like

the opportunity to keep it on the table to look at that. Because of the way the FQ is set up for Part A where we have an NPI location for every satellite clinic that we have under our organization, that's tied back to our PTAN. Our PTAN does not go on the claim but the NPI goes on the claim which feeds our data that we need for our cost reports and our PS&R reports that we get.

When those things tend to come over to Medicaid and there's nothing there to bump up to, I just find that the claims seem to work cleaner and we get clean claims when those same things are registered and on file at DMS.

(Mr. Barry Martin comes in)

MS. GUICE: We will certainly do a little bit more research and bring you some screen shots to show you the limitation because that's the word we got. The limitation is not ours. It's from someone else. We'll show you that and show you whether or not we can waive that limitation or not.

MS. AGAN: And, then, how do we handle that? What's going to happen when those claims come over and those individual NPIs are not there?

MS. GUICE: Well, I think that

the issue, then, rolls back to you and how you're handling your enrollment and what your groupings are because I can't say. I didn't even understand all of the acronyms you used when you were talking about that.

MS. AGAN: Okay. Sorry.

MS. GUICE: No. That's okay. I'm just saying that that's what we can do.

MS. AGAN: Okay. Well, let's start there.

MS. GUICE: I don't have enough knowledge about how provider enrollment works and why you would need more than thirty.

MS. AGAN: We use it in our Medicare Part A billing.

MS. GUICE: And I understand that you understand that. I don't and you don't need to explain it to me now. So, I'll go back and ask the experts about it and we'll come back with something. We'll give you maybe some more information about what your options are.

MS. AGAN: Okay. That would be great. Thank you.

MR. CAUDILL: I think part of this also is required for sites. A lot of us are

doing school-based clinics. So, each school has to be licensed as a separate site and some of the FQHCs may have as many as a hundred schools, so I've been told.

MS. GUICE: Okay.

MS. KEYSER: Mike, this is Chris. I've got a question for Yvonne. Yvonne, what happens? I mean, is this related to you getting billing denies? So, if you had a thirty-first satellite clinic under your organizational NPI, what is happening? You're getting denials?

MS. AGAN: I think it has the possibility of affecting those crossover claims and that's what I'm trying to open the door of conversation to find out if that's a possibility of some of the crossover claim denial problems.

MS. GUICE: So, you haven't had any problems yet.

MS. AGAN: I personally haven't but I've been asked to bring it up for other groups.

MS. GUICE: Okay.

MS. ELAM: There are problems. There are problems.

MS. GUICE: Okay. So, it would be helpful along with this review that we'll be doing

to have one or two examples to take a look at.

MS. AGAN: Okay.

MS. GUICE: Just one or two, though. We don't need a thousand.

MR. CAUDILL: Any other comments?

MR. HARILSON: Yvonne, if you have examples, when you get back, if you want to just give those to me and, then, I can share those back over to DMS.

MS. AGAN: Okay.

MR. CAUDILL: All right. If no further comments, let's go to Item E, reimbursing colorectal screenings at age forty-five. This relates to KRS 304.17A-257 that has an effective date of January, 2020 which states the American Cancer Society guidelines on screenings should be followed.

And I think the question arises, we wanted to make sure that the MCOs are complying with both payments and utilization management.

MS. HUGHES: I did check with Angie Parker on this and she told me that, yes, they are complying. Now, if you want to ask individually, feel free.

MR. CAUDILL: Okay. Do the MCOs present agree with the statement made by Ms. Hughes that the MCOs are all complying with this?

MR. GROVES: This is Ken Groves. Agree, yes.

MS. STEPHENS: Humana agrees.

MS. RUSSELL: WellCare agrees.

MS. DRAKE: Passport is not sure but I can find out.

MS. ASHER: Aetna, it's a takeaway. Yeah, we're working on that now to make sure that we are complying.

MR. CAUDILL: Okay.

MR. HARILSON: I will follow up.

MS. KEYSER: Mike, what is colorectal screening? Does that include colonoscopies? Are we talking about the FOBT test or both?

MR. HARILSON: I can respond to that if you'd like because that was part of my followup.

MR. CAUDILL: Sure.

MR. HARILSON: The regulation quoted states: A health benefit plan issued or renewed on or after January 1, 2016 shall provide

coverage for - and I'll circle this word - all colorectal cancer examinations and laboratory tests specified in the most recent version of the ASC Guidelines for Complete Colorectal Cancer Screening of asymptomatic individuals as follows.

And, then, it goes on again: Coverage and benefits shall be provided for all colorectal cancer examinations and laboratory tests.

So, Chris, to answer your question, if you go look at those ASC Guidelines, it mentions the stool-based tests that are acceptable, as well as the exams of colon and rectum which you listed some from both of those.

And, so, it is our interpretation that the word all means all. And, so, the MCOs would have to cover all of the tests and options that are in the guidelines.

MS. KEYSER: Thank you.

MR. HARILSON: And, so, I would just pose that back out to the MCOs to make sure that when Angie Parker says that they are in compliance, that is actually all.

MS. GUICE: So, the only change in 2020 I believe was to drop the age to forty-five instead of fifty, correct, that statute that was

effective 2020?

MR. HARILSON: Yes.

MS. GUICE: And the ACS new guidelines, the only thing that changed in their guidelines was to drop the age from fifty to forty-five, correct? So, if everybody was in compliance before then, they should be in compliance if they----

MR. HARILSON: Hopefully so. I couldn't tell you if they were in compliance before then or not with the tests that they are covering.

MS. GUICE: Sure.

MR. HARILSON: But the age is definitely one of those things because as we go out and educate clinics on this screening and they start billing at forty-five and they were getting denials because UM and/or payment was set up for fifty because they weren't following the reg.

So, that is kind of where it started but we just wanted to make sure that it wasn't just the age, that it was also for the lab tests and the other options.

MS. HUGHES: Are you getting denials?

MR. HARILSON: That I can't - it's more of a question just to make sure that there

is compliance to the reg as we interpret it with the word all, what's in the guidelines.

MS. GUICE: Right. When Angie gives a response like that, it's because she sent a question out to the MCOs and the MCOs have responded to her and, then, she has made this response.

So, if you have some examples of those codes not being paid, we would certainly like one or two and one or two from each MCO if that's what you have. Just send them and we'll take a look.

MR. CAUDILL: Comments or questions?

MR. INMAN: This is John Inman with KPCA. Noel, do we have any documentation or anything saying that it's contrary to the statute saying that we either cover this or this from any of the MCOs?

MR. HARILSON: We have one.

MR. INMAN: Okay.

MR. CAUDILL: All right. Under Item F, updates or announcements from the MCOs. If you all don't mind, do you have any announcements to make or anything you would like to update? Let's go around the room and start with you.

MS. WERKEL: So, Michelle Werkel from Humana. I think that transition from the previous administration with the dual administration with CareSource to Humana being the sole administrator for the Humana Medicaid plan is doing well. We're out in the market meeting with all the providers, getting in to the clinics, certainly meeting with KPCA on a regular basis.

So, those Provider Relations' folks are out and trying to do visits. We're trying to hit every provider in the first quarter to get faces and names with who their new relationship owners are.

So, otherwise, I think things are going well. Certainly if there are feedback or comments that need to be addressed, those can be routed through my team, but, otherwise, that's what the majority of our activity has been as the first quarter is just trying to get out and make sure everybody knows who their relationship owner is in light of the transition.

MR. CAUDILL: Thank you. Next.

MS. ASHER: I'm Sammie Asher, Aetna. We have recently last week actually kicked off our Aetna Provider Partnership Program. We have

kicked that off last week. It's really successful.

We're still sort of in recruiting mode. So, we're looking for providers to join us. It is a commitment for a year. We'll be meeting quarterly.

So, if you have any providers wanting to join and attend, we would love to have them. And when I say providers, we're looking at it at all aspects. Last week, we had actual providers, we had billing managers, we had office managers. So, we just want collaboration to make sure that we're hitting the issues that's outstanding. We're picking their brains, so to speak.

So, we're really excited about it and last week was very successful. So, contact me if you have any providers wanting to join.

We also have our network communication campaigns going on. Obviously, we do the fax blast if there's any network changes.

We also have our Tips Tuesdays going out to the providers every Tuesday which has been great. Providers are loving them. If you know of a provider not getting them, please have them contact me and we'll get you on the mailer and that's about it.

MR. CAUDILL: Okay.

MS. DRAKE: Christine Drake with Passport. We do continue sending our E-News for the most up-to-date information and same thing. A lot of the reps, lots of transitions within and we're all getting out and working closer one-on-one with providers to let them know who those reps are and to continue those partnerships.

MR. CAUDILL: Thank you. Over here.

MR. GROVES: This is Ken Groves with Anthem. So, I've got a few things here.

The first thing is - and I will probably send this over to KPCA - we have a notification that's going out that's called My Diverse Patient.

So, this basically is education to clinics and staff about educational resources for education on health disparities. I think it will be some really good material for those folks to have.

The second thing is our Provider Relations' maps are posted. I'll let you know about that. so, basically, we have Unify. So, if any of you guys, the clinics will contact the Provider Network Relations consultant, you can

address any issue regarding Medicaid, all lines of businesses. So, it's a one-stop shop. So, that's a game changer there. So, again, that's on our provider website.

Another thing is we have a HEDIS education coming out as well, HEDIS 101. That will be some great information for your clinics as well for education.

And the last thing is Anthem has a partnership with KHIE. So, basically, this is a grant opportunity that we'll be putting out to the provider community in reference to a grant that can be awarded up to $2,000. So, you will be getting information about that as well.

MR. CAUDILL: Thank you. Have I missed any of the MCOs?

MS. RUSSELL; Pat Russell with WellCare. Just as couple of things. I want to remind everybody we're still doing our webex's where we focus on different topics, whether it's filling out your CAQH or if it's something we've got going on around actual clinical parameters that the clinics might need to know how to access our portal, how to use the portal, all those great things.

We are also scheduling our

spring summits. Those will be in May. We have the dates. We don't have the locations yet. They will be located strategically across the state. So, once we get the locations locked down, we'll make sure everybody is aware of where those are and the dates.

MR. CAUDILL: Okay. We thank each of you all.

Steve, is there anything you would like to address?

MR. BECHTEL: No. Well, I'll just tell you some of the things I've been looking at is I've been looking at the health rankings for Kentucky. We're 43rd in the nation. I know that sounds bad but we used to be 48th and 47th. So, we are moving the needle.

Then, I went to the county rankings and it shows that in Eastern Kentucky is the place where we need to concentrate the most on trying to improve the health outcomes of our members.

I'm open to suggestions or ideas of how to address those measurements and try to improve the health care of our members in those areas.

I'm not saying that the whole state doesn't need to be addressed but it looked like

Eastern Kentucky, there were some really bad numbers in Eastern Kentucky that we need to sit down and figure it out.

MR. CAUDILL: You're talking to the choir.

MR. MARTIN: Any focal points that you can mention?

MR. BECHTEL: Health disparity is one as you mentioned. Some of the other things were unexpected deaths. Of course, the elephant in the room is opiates.

MR. CAUDILL: We'll be happy to sit down in Eastern Kentucky and have prolonged discussions with you about that.

MR. BECHTEL: I do have plans - and I don't know if it's in my purview - but I've already talked with Barry and some - I might be showing up at some of your clinics in Eastern Kentucky just to make a face.

I know we had that with David Gray. David Gray is no longer with the Cabinet. I'm not trying to fill his shoes by any means, but based on what I said at the beginning, I'm right there with you guys on the frustrations and I think I mentioned to Barry during transition that I wanted to get out

so that you all feel like you have a partnership with the Department.

MR. CAUDILL: Thank you. We certainly look forward to that. And let me also reflect for the record that Barry Martin is present.

MR. MARTIN: Yes. I apologize for my tardiness.

MR. CAUDILL: Under Item G, the next item is new items for discussion. Do we have anyone that would like to speak up about that?

MR. INMAN: Mr. Chair, John Inman with KPCA.

MR. CAUDILL: Okay, John, and speak up because I don't hear well.

MR. INMAN: Okay. I'd like to talk about Senate Bill 50, that small bill that's in the Legislature now that everybody is talking about, pharmacy benefits in Medicaid.

It does have an emergency clause with it. From everything that we can tell, its passage is imminent and it does substantially materially change the way that pharmacy claims are processed for Medicaid MCOs through the State procuring a single PBM to administer the pharmacy

benefits.

So, I think in light of that, the Policy and Procedure Manual should probably be delayed on implementation or retracted so that that particular issue of the procedure manual be addressed in the RFP.

MR. HARILSON: Is that something that the committee would like to make a formal recommendation to the MAC on?

MS. GUICE: You mean the 340-B policy.

MR. INMAN: The 340-B policy.

MR. CAUDILL: Let's see if the Department has any comments on that. Okay.

MS. AGAN: Do we want to make the motion, then?

MR. CAUDILL: Well, the next thing is recommendations to the MAC on the agenda and that would be the appropriate place to bring it up, I think. Anyone else who would like to speak to this?

DR. MULLINS: Question. John, I know in the legislative process, things change quickly. Could you just summarize what these changes are for some of us that are not totally right on top of that? What are the implications and what are the

major things that are going to happen now?

MR. INMAN: Sure. So, currently, the Managed Care Organizations subcontract with their own Pharmacy Benefit Manager. Four of the five is CareMark.

DR. MULLINS: I understand that.

MR. INMAN: But what this bill does, it mandates that the Medicaid agency procure a separate PBM. It mandates that they procure one for use by all of the MCOs. So, the State would issue procurements for a Pharmacy Benefit Manager and, then, all of the MCOs would be required to subcontract with that single PBM.

There are some other changes in there as to how the PBM would operate but that's a short summary.

MR. CAUDILL: I should say that the vote in the Senate was unanimous.

MR. INMAN: It was. It was. And in talking to House members, it won't be changed as to its current overarching form. There may be some technical amendments to it but the structure will remain in place of the one PBM.

MR. BOLT: David Bolt. I think the reason for delaying the implementation of a

policy, the rationale there is that we will have legislation and we actually think that this is something that should be covered under regulation, not under some policy change. Is that correct, John?

MR. INMAN: Yes, because it does set certain parameters for the PBM to be promulgated in an administrative regulation into the bill. So, this could probably be added to that promulgation.

MR. BOLT: So, you could potentially have a policy going into effect in April and something different being in place by bringing this single Pharmacy Benefit Manager into place.

MR. INMAN: Correct.

MR. CAUDILL: Okay. No further comments or questions?

MS. ELAM: I think we need to mention the UB modifier being a part of that discussion.

MR. INMAN: Yes. As part of the 340-B discussion, the UB modifier is to be added to any clinic-administered claims, but taken as a whole, we're asking for the entire manual to be retracted or delayed which does cover our clinic-administered drugs, for 340-B purchased drugs.

MR. CAUDILL: Any further

comments?

Then, let's move to Item H which is recommendations to the MAC.

MS. AGAN: I'm not as well-versed as John is, but I believe that we need to make the recommendation to delay the implementation of the Policy and Procedure Manual to allow opportunities for the clinics to respond and react to what they need to do during this implementation.

MR. CAUDILL: Are you making that in the form of a motion, then?

MS. AGAN: Yes.

MR. CAUDILL: Is there a second to that?

MR. MARTIN: Second.

MR. CAUDILL: Seconded by Barry. Any further discussion? There being none, all those in favor, say aye. All those opposed, say likewise. The motion carried to make the recommendation to the MAC along with Member Agan's motion.

The next meeting scheduled is May 7th which will take place here. Is there any other business to be brought before this group?

MR. HARILSON: Sharley, do you need that recommendation on the record or can we just

send you the recommendation for the MAC?

MS. HUGHES: It should be on the record, yes.

MR. HARILSON: All right. So, read the recommendation.

MR. CAUDILL: The recommendation, then, for the record will be due to the imminent passage of emergency legislation and Senate Bill 50 and as a requirement of one state-procured PBM for administration of pharmacy benefits of all MCOs and the material change it will make to the current pharmacy claims system, the TAC requests a delayed implementation or retraction of the 340-B Policy and Procedure Manual.

There being no further business, if no one has any further comments, the Chair will entertain a motion for adjournment.

MR. MARTIN: So moved.

MS. KEYSER: Second.

MR. CAUDILL: All those in favor, say aye. All those opposed, stay here while the rest of us leave. Thank you for coming.

MEETING ADJOURNED