CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID
CONSUMER RIGHTS AND CLIENT NEEDS
TECHNICAL ADVISORY COMMITTEE MEETING

****

Via Videoconference
April 20, 2023
Commencing at 1:32 p.m.

Shana W. Spencer, RPR, CRR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Emily Beauregard, TAC Chair

Miranda Brown

Arthur Campbell, Jr.

Patty Dempsey (not present)

Brenda Mannino

Christy Hardin (not present)

MS. SHEETS: I'm going to take over as host as Erin is still having some technical difficulties. So give me just a minute to get the agenda up, and I do apologize.

CHAIR BEAUREGARD: Oh, no problem. And if you happen to see Arthur or Patty come into the waiting room, just let me know.

MS. SHEETS: I will.

CHAIR BEAUREGARD: I keep scrolling through the list, but it's hard to keep track. I do want to tell everyone -- well, first, welcome. Thank you all for joining us today and also for your flexibility. I know our meeting was scheduled for Tuesday and had to be rescheduled, so I appreciate you making time to join us.

I did get an email from Christy Hardin this morning, our representative from the FRYSCKy coalition, and she lost her daughter recently. So she is not going to be able to join us. I'm not sure if she'll be attending our upcoming meeting either, but I'll try to touch base with her after a few weeks. So that was very sad news, and I just wanted to

pass that along if you wanted to keep her in your thoughts.

I don't know that we can establish a quorum yet, so we may want to just skip down to old business and start going through our usual items. And then assuming we get Arthur and Patty on, we'll be able to establish a quorum and do some voting if we need to.

So why don't we go ahead and go over the old business items that we have here. The first is our standing data requests. We always want to get an update on how many Kentuckians are currently covered under some of those different eligibility programs.

Oh. Hi, Arthur, I see you. I see you on now. Thanks for joining us.

And, in fact, I think I kind of skipped ahead. So before we do old business, we should do introductions. Sorry about that. Brenda, I know we've talked. This is your first meeting, though.

MS. MANNINO: No. I think I attended --

CHAIR BEAUREGARD: This is your second meeting.

MS. MANNINO: Yeah.

CHAIR BEAUREGARD: Okay. But I do think that we should all just do introductions so that we're all familiar with who's a member of the TAC. I'm Emily Beauregard, director of Kentucky Voices For Health, and I've been chairing the TAC for a few years now. If Brenda, Miranda, and Arthur, if you would just introduce yourselves in that order.

MS. MANNINO: Okay. I'm Brenda Mannino. I am a retired lawyer. I live in Lexington, and I'm representing AARP.

MR. CAMPBELL/INTERPRETER: Arthur would like to introduce himself. He says I am Arthur Campbell, Jr., and I am representing DPA and myself on the TAC.

MS. BROWN: (Inaudible) a member of the TAC. I have with me today Cynthia Hess who is also from Kentucky Equal Justice Center. And -- yeah. So thank you.

CHAIR BEAUREGARD: Great. Thanks. I did see Cynthia on, so thanks for joining us, Cynthia. Kelli, have you seen Patty in the waiting room yet? Has she been able to

join?

MS. SHEETS: I do not believe I've seen Patty. I do believe, though, you now have a quorum.

CHAIR BEAUREGARD: We do have four members. Yeah. Okay. So we'll go ahead and establish a quorum, and we can go to Item 3, approval of the minutes from the previous meeting which, of course, is a long transcript. But, hopefully, you've had a chance to glance at it.

MS. SHEETS: I would just like to take this opportunity to remind the members that in order to comply with open meeting laws, if you're voting, you need to have your camera turned on.

CHAIR BEAUREGARD: Is there a member that doesn't have a camera turned on?

MS. SHEETS: It doesn't look like Arthur does.

CHAIR BEAUREGARD: Oh. I see Arthur.

MS. SHEETS: There he is. And then Brenda, I don't see her, but it could just be a technical glitch on my end.

CHAIR BEAUREGARD: Yeah. I'm seeing Brenda, too. I see Miranda, Arthur, and Brenda right now, so it may just be --

MS. SHEETS: Okay. Great. Thank you.

CHAIR BEAUREGARD: It may just be Zoom. You know, sometimes Zoom doesn't have all the, like, video boxes on the screen, so that makes it tough.

All right. So we can approve the minutes. Can I get a motion for that?

MS. BROWN: Motion to approve the minutes from the previous meeting.

CHAIR BEAUREGARD: Thank you. And a second?

MR. CAMPBELL: I second.

CHAIR BEAUREGARD: Thank you, Arthur. All in favor, say aye.

(Aye.)

CHAIR BEAUREGARD: Any opposed?

(No response.)

CHAIR BEAUREGARD: All right. The motion carries. Thank you all.

And now I'll go to old business and our standing data requests. Kelli, do you know

who is on from Medicaid, who is going to be touching on these items?

MS. SHEETS: I believe -- I'm sorry. We are so disjointed here with all the technical issues. Are we at No. 4, the data requests?

CHAIR BEAUREGARD: Yes. Old business.

MS. SHEETS: Okay.

CHAIR BEAUREGARD: And then starting with A, the standing data requests.

MS. SHEETS: Is Angie Parker on? I know she was going to address part of old business. I don't see her on.

CHAIR BEAUREGARD: I don't see Angie on.

MS. SHEETS: We do have -- I will tell you we do have the -- wait. Let me admit Veronica and Rachel Roehrig. We do have the Medicaid forums going on, so we've had a lot of staff out traveling. So it's made it very difficult for people to join these meetings. But now that Veronica is in, maybe we can ask her.

CHAIR BEAUREGARD: No problem.

MS. SHEETS: Veronica, we're at No. 4, old business.

CHAIR BEAUREGARD: So, Veronica, we've just gotten to this item. So if we can start with the standing data requests, just how many Kentuckians are covered under these various categories.

MS. CECIL: Okay. Is Justin not on?

MR. DEARINGER: Hi, Veronica. This is Justin Dearinger. I do not have that information in front of me. I think we have -- I hadn't gotten back -- that back from anybody from eligibility yet, so we don't have that. So we can get that to you, you know, this week for sure.

MS. CECIL: Yeah. Apologies, Emily, for that and to the TAC members.

CHAIR BEAUREGARD: All right. Well, if you could just follow up with an email, that would be great. And I'm assuming that's true for both the traditional Medicaid and 1915C waivers?

MS. CECIL: Yes.

CHAIR BEAUREGARD: Okay. So I have

a feeling that you'll be able to cover the next one. As far as the status of the PHE unwinding and Medicaid renewals go, can you give us an update?

MS. CECIL: I sure can. And, in fact, I have hot off the presses -- let me share my screen, and we'll -- Erin or Kelli, if you all can make me --

MS. SHEETS: I'll see if I can, Veronica. We're having some technical issues.

MS. CECIL: Uh-oh. Okay.

MS. SHEETS: Okay. I can do it. I just made you cohost so...

MS. CECIL: Yes. Great. Thank you. I am going to take over here. Okay. All right. Can you see that?

UNIDENTIFIED SPEAKER: Yes.

MS. CECIL: Okay. So as of -- for the -- you know, the first individuals up for renewal are those with a May 31st, 2023, renewal date, and notices have gone out. Our system on April 1st did try to do what's called ex parte, or automatically renew folks that we are able to passively renew. And

those individuals -- so our system goes out and pings all the databases and verifies income or assets and goes out and verifies that information.

And if we are able to verify them, they are what we call passively renewed, and they don't have to take any additional actions. If we were unable to passively renew them that way -- and that's because just something -- there's just one little thing maybe that we just couldn't completely verify through that process, they're going to get a request for information, an RFI.

We are, you know, being sensitive to the fact that this is the first time that we are starting renewals. We are taking action on a change in circumstance, all -- for all those reasons. We are trying to be proactive and to give people an opportunity to provide us information if our system even went out and maybe found somebody ineligible. So we're dropping that to a request for information during this process to give them that second chance of providing us the information that we need prior to that end date.

And then we have those individuals that receive a renewal packet, and those are -- although we'll go out and ping the databases to the extent that we can, these are individuals that have some type of asset or resource test that is not information that we can necessarily be able to gather through that automatic verification process.

So we already call those an active renewal. So we'll go out. We'll pull as much information as we can and then drop that to a renewal packet pre-populated with the information that we have on file and send that to them and ask them for verification or for the additional information, especially knowing that over the past three years, circumstances may have changed to provide that to us. They have to take action prior to their end date.

So we have passive cases and active cases. So for those with a May 31st, 2023, renewal date, there were 72,421 cases. We do do things at the case level. So we have 1.7 million people, but we only have about 860,000 cases to go through redetermination.

The cases are generally developed by members of the household. So there's a head of household and then members of the household, and their eligibility generally is based on the income of the household. So that's why you'll see sometimes we're talking about cases, and sometimes we're talking about individuals.

But for Medicaid again, for May renewals, a little over 72,000 cases. Of those cases, 49,491 are passive cases. So those are ones that are -- kind of fall into that bucket of it's likely just an income verification, not a resource test for eligibility. So we can go out and have the ability to passively renew those individuals without any additional action on their part.

The -- and then the rest of those cases, the 22,930 are the ones that would receive that active renewal packet. Of the passive cases, we were able to passively renew 60 percent of them. So they don't have to take any action. We've renewed them. They're getting a notice of eligibility letting them know their coverage has been updated. Their

renewal date will change from May 31, 2023, to May 31, 2024, nothing further from them.

And so that's a little lower than what our normal passive renewal date is. But, again, I think the reason for that is because we've got a lot of people we've been holding on and keeping covered that are no longer eligible. But we want to give them -- even if through passive -- the passive renewal process we're unable to verify, we're dropping to a request for information. So that's why the cases are going to be -- the passive renewals are going to be a little lower right now.

Of the active renewals, you'll see 479. This is just of April 12th. But 479 have completed that active renewal process, so they've completed the renewal packet and submitted that to us. 347 of those have been determined eligible. 50 of them have transitioned to a qualified health plan and are advanced premium tax credit eligible, so APTC eligible.

For those who do not know, that will -- that APTC really makes that qualified health

plan more affordable because it could cover all their premiums or make their premium very low, so it makes it more affordable.

But what our system has done is taken those 50 and transferred them over to the state-based marketplace, Kynect, so that they can shop on a plan. So they've gotten a notice to say, hey, you're eligible for a qualified health plan, an APTC. You need to take action to choose a plan.

These individuals are getting additional outreach and support from us and from their Managed Care Organization so that they take that action to shop for a plan prior to May 31st so that there is no gap in their healthcare coverage as they move off of Medicaid but onto a healthcare plan, a qualified health plan.

And then of those renewals that we've completed, 82 have been determined ineligible. While our -- while we could not determine whether they're QHP/APTC eligible, we'll be providing support to these individuals as well to understand that maybe there are some other options available to

them prior to the May 31st end date.

Maybe there's an employer plan available. The loss of Medicaid is a qualifying event. Or perhaps they are QHP eligible, but for some reason, we were not able to automatically transfer them.

So while determined ineligible doesn't mean that we're not, you know, doing anything further for them. We're going to make sure they understand they need to take action.

CHAIR BEAUREGARD: Thank you, Veronica. Were you going to continue -- can I ask a question?

MS. CECIL: One more slide.

CHAIR BEAUREGARD: Okay.

MS. CECIL: Sorry. So just -- I mentioned those 22,930 active renewals have received a renewal notice in the mail. There were 19,713 cases that we dropped to a request for information. We did not want to discontinue these folks without giving them that opportunity to provide information to us.

We sent over 42,000 email messages approximately 90 days before the members' end

date to let them know that they have a renewal coming. And then we did 1,438 (sic) email messages about 60 days prior to that end date that was nearly simultaneous with their notice to let them know that they have an active renewal that they need to take.

And then of the calls that we've made -- because what we did, once that ex parte ran and we dropped and we saw who all had either a renewal packet or a request for information -- so they have to take action -- we have called every single one of those cases.

And so we have -- we reached over 8,400 of those cases. We were actually able to reach them and have a conversation, make sure they know that there's an active renewal, and they have to take action. We left messages for a little over 8,000 of those.

And then in addition to that -- so that happened, you know, the week after the April 1st ran. We have done nudges. We've done a little over 4,300 nudges. Those are individuals where we've received information, but it's not enough. And we need additional

action. We've called those individuals and also tried to reach them to say we know you sent something, but we still need to verify something. And that has led to an update. And then for a little over 11,000, we have -- or close to 12,000, we've also left messages to make them aware that -- to take action.

Between now and the end of May -- and this will be for every month that there's a renewal -- our system is pulling individuals who have not taken action, and those are the ones we're going to continue to call.

They may get tired of hearing from us. They may get tired of hearing from their Managed Care Organization, but we feel like that that's, you know, a risk we're willing to take to make sure people understand what's happening.

CHAIR BEAUREGARD: That's really good information to have. I wanted to make sure I'm remembering correctly, that the first month of renewals included people who aged out of Medicaid and are now Medicare eligible; is that right?

MS. CECIL: So yeah. So between

May and October, we distributed cases -- so over a six-month period, we've included cases for anybody who is Medicare eligible, 65 years or older. The majority of those individuals had filed for Medicare during the three-year Public Health Emergency, so there really is just a small number that we know we need to be really proactive with in understanding what they're -- what they need to do prior to May 31st. Because we want to make sure they file that application by that date so that there's no gap in their coverage.

CHAIR BEAUREGARD: So for those individuals, they would fall into that category of ineligible that you mentioned; is that right?

MS. CECIL: Yes. It's very possible.

CHAIR BEAUREGARD: Okay. And do you expect that since Medicare members, or Medicare eligible, were -- got this first renewal packet or were in this first renewal period, do you expect that next month, we'll see fewer ineligible or fewer who are going

to be --

MS. CECIL: No. We -- we took those cases and pretty much evenly distributed them over the six months.

CHAIR BEAUREGARD: Oh, I'm sorry.

MS. CECIL: It's very possible we'll see similar numbers across the May through October.

CHAIR BEAUREGARD: Okay. And then -- I had one other question, but now it's -- I'll think of it.

Did anybody else have a question?

MS. MANNINO: So we don't have that information today about how many Kentuckians are currently covered under Medicaid?

CHAIR BEAUREGARD: It looks like in the chat, we do know the number of people now covered by Medicaid, which is 1.7 million.

MS. MANNINO: Okay.

CHAIR BEAUREGARD: About steady with what it's been for the last couple of months, I think. But if this month is, you know, similar to future months, I think we would be seeing a pretty big decrease. So I'm hoping that this month, you know, maybe

is just a little bit different in terms of how many people look like they are no longer eligible. But, of course, it's pretty early. I think they have how many more days to respond?

MS. CECIL: Oh, they have up until May 31st.

CHAIR BEAUREGARD: Right. And so while we have only seen, you know, less than 500 renewals completed, there's much more time. And so the more that we can be doing as, you know, advocates and organizations, MCOs, to -- providers, of course, to spread the word and make sure people are looking for that information, helping people find their renewal date.

I don't know if this has been covered on this call, Veronica, but there are some ways to find your renewal date, which I think is really, really helpful. So can you just describe what those are?

MS. CECIL: Absolutely. So for a member, they can call in to the Kynect hotline and find their renewal date. They can get into Kynect and find their renewal

date. We -- I just got off of a provider forum where we are encouraging providers -- because we have added the redetermination date to Kynect -- I'm sorry, to KYHealth-Net, which is the system that providers go in to look up a member and verify eligibility. So we've added the redetermination date to that.

And we're asking providers that when you have a member in your office, to share the date even if it's, you know, down the road, in December or January, just to give them the redetermination date.

And then we are providing a lot of resources to providers so that they can take the next step. If somebody has a redetermination date that's coming up very soon, how to connect that person to resources to help them, a connector, insurance agent, to call the Kynect hotline, or to go onto their Kynect account. So yeah, there are multiple ways to access that information.

CHAIR BEAUREGARD: Okay. Thank you. That's really helpful. I did notice that your return mail rate was really low, which makes me think that it was successful

in getting people to update their address. Do you feel the same?

MS. CECIL: I'm not yet going to share complete optimism because that was as of the 12th. And, you know, the renewal packets went out kind of that week before, so I'm going to --

CHAIR BEAUREGARD: Okay. We'll wait until next month to decide on that one.

MS. CECIL: We're closely monitoring it, though.

CHAIR BEAUREGARD: I just think a lot of us have feared that many people have moved and not updated their information and would be not receiving that, you know, in the mail because of that reason so --

MS. CECIL: That's the other thing we've -- yeah. That's the other thing we've asked providers, is -- we understand that when the patient comes in, you're always asking them to update their contact information with you -- is to ask that question. Well, if there is a change, have you told the state Medicaid office about that change? Just to ask that one question if

they see that there has been a change in their address or phone number or, you know, if they have an email address on file with the provider. So it's another opportunity for us to drive home the importance of that reporting to the state.

CHAIR BEAUREGARD: Well, we'll look forward to getting next year -- next year -- next month's report and seeing how it all compares.

But, Brenda, to your question earlier -- well, and since you are a representative of AARP, I just wanted to make sure you are aware that for all those members who have become Medicaid or Medicare eligible, there is a special enrollment period that is available to them.

MS. MANNINO: Uh-huh.

CHAIR BEAUREGARD: So I can share that information with you, you know, offline but --

MS. MANNINO: Well, that's -- isn't that usually within three months of their birth date?

MS. CECIL: No.

CHAIR BEAUREGARD: So the special enrollment period means that they have more time.

MS. MANNINO: Okay.

CHAIR BEAUREGARD: Yeah. So that's --

MS. CECIL: Yeah. It's a six-month period that starts when they lose their Medicaid. So it's a rolling special enrollment period based on the individual and their end date in Medicaid. They won't be penalized if they -- if they file within six months of that end date. But we want them to file before their end date because we don't want a gap in coverage, so that's important.

MS. MANNINO: Right.

MS. CECIL: The other thing for our Medicare population is that, you know, we're -- the resources that we're providing to them, and when we call them, make them aware of if they need help filing that application to Medicare, is the state health insurance assistance program, the SHIP counselors, and our sister agency, the Department For Aging and Independent Living.

They are on notice and waiting and are available to help those individuals age 65 and older with navigating the Medicare application process.

MS. MANNINO: Great. Okay.

MR. LEVITZ: I have a question for Veronica. First of all, great work. Amazing early results. Y'all should feel very proud of all the work you've put into that.

MS. CECIL: Thank you.

MR. LEVITZ: My question is, if a Medicaid enrollee is disenrolled but feels there was a mistake and would like to appeal that decision, how do they appeal? And while they're in the appeal process, would you confirm that they will maintain Medicaid coverage until that's been resolved one way or the other?

MS. CECIL: Sure. So two -- two actions actually for somebody who has been disenrolled. One is administratively disenrolled. So they didn't take action, but they get that notice that they've been discontinued. If they provide that information within 90 days past their end

date and we're able to determine their eligibility, then we will reinstate them back to that end date with no gap in coverage. So there is opportunity within that 90 days after if we had not made a determination for them to get that information or verification to us.

If we've made a determination that they're ineligible and they want to appeal that, that information is contained in their notice. It goes with their notice of ineligibility, and so they can follow the directions that are in that. If they need help with that, you know, there's lots of resources to help them file that appeal.

And yes, we will continue to cover somebody who has a pending case until the conclusion of that.

MR. LEVITZ: That's wonderful. Perfect. Thank you so much for that answer.

MS. CECIL: You're welcome.

CHAIR BEAUREGARD: Good question. We had a couple of things to clarify. One, I think we -- Arthur may have asked about this on our last call, our last TAC meeting. The

renewal process for individuals with SSI, they do have to complete that full renewal packet. But I think it was maybe not clear last time, is that it is at least prepopulated. While you can't do a passive renewal, you can do some of the pinging of, like, the federal hub and everything and update information.

MS. CECIL: That's correct. And, likely, what that prepopulated form is going to show -- if it shows, like, a higher SSI income, you know, it should show that so that you'll know what it is that we can see in our system.

CHAIR BEAUREGARD: Okay. And one other thing that we've heard for a number of months now, and Miranda actually brought another example up to me yesterday. Some people have been receiving notices of eligibility even though the renewal process hasn't started yet.

So if someone just received a notice that had their eligibility end date of May 2023, they have not actually gone through the renewal process. Am I right?

MS. CECIL: If they have a May 31st, 2023, end date, that is likely their redetermination date. So if they've received, like, a renewal packet or a request for information or a notice of eligibility -- because we were able to go and -- although this shouldn't be happening -- verify that their income is over the limit, then they may have received a notice of eligibility to let them know that their coverage may end because of that.

Miranda is providing us some examples, so we can just make sure.

CHAIR BEAUREGARD: Okay.

MS. CECIL: I will say --

CHAIR BEAUREGARD: Would they not be also receiving a letter that says that they are no longer eligible, or is it maybe just a matter of the timing?

MS. CECIL: No. They should receive a letter saying that they're no longer eligible as well. That's correct. I do know that, you know, our system is not perfect. And when we suspended requests for information, when we went back to turn back

on normal operations, some of them got out and -- but, again, we really want examples, so we can track it through the system just to make sure that, you know, we haven't missed anything in terms of if there's something we need to fix in our system.

CHAIR BEAUREGARD: Okay. Miranda, did you have anything else you wanted to add or any other questions before we move on?

MS. BROWN: Hi, Veronica. The notices that I was talking to you about (inaudible) --

CHAIR BEAUREGARD: Your sound is a little bit quiet and muffled to me, if you can just maybe speak up or get closer to your mic.

MS. BROWN: Is that better?

CHAIR BEAUREGARD: Not a lot.

MS. BROWN: I don't know how to fix that. I'll type in the chat.

CHAIR BEAUREGARD: Okay. I mean, I think I can make out most of what you're saying, but yeah. Sorry.

Veronica, while we're waiting for Miranda's comment, there is going to be a

dashboard published soon; is that right, a public dashboard? Do you have a date in which --

MS. CECIL: I do not. We're working on it.

CHAIR BEAUREGARD: Okay. All right. So the issue is the Kynect. So on the self-service portal online, the coverage end dates are inconsistent with some of the notices. Okay. Yeah. Any clarification would be really helpful, and I think a lot of connectors may be experiencing some of that.

MS. CECIL: Okay. And one thing that we'll do is -- you know, I think David Berry has been doing a really great job of sending information out to connectors as we discover things to keep everybody in the loop. So we'll look into those and send out some messages if it's going to be beneficial to everyone understanding what's happening with the inconsistency.

CHAIR BEAUREGARD: All right. Well, thank you for all those updates. It's really good information to have.

And I think we can move on now to the next item, which is just getting a status update of the HCBS rate study workgroup.

MS. SMITH: So -- and I'm sorry, you all. I'm having camera issues today.

So the rate study -- so where we are right now is we are -- it is finished. It is still in kind of final, like, executive-level review. But right now, we're in the process of implementing that -- the 10 percent that was given in House Bill 1, the first 10 percent.

So the changes are going -- I approved testing for the changes to go into the system hopefully by the end of this month. I know they're working on them, but it was an incredibly tedious update. I think we -- you know, it doesn't sound like there's that many services. But the way they're broken out, I think we ended up touching 251 rate segments. So we want to make sure we have it right, so we were very thorough in reviewing testing and very thorough in the changes getting implemented.

Then the next step that will happen is

that we will do mass adjustments for the traditional providers and then -- so, Arthur, on the participant-directed side, we're meeting with the ADS to let them know that they now also can start -- in meetings with participants, that they can start talking to them about moving forward, that participants have the option to modify the rates an additional 10 percent for their employees.

So that meeting -- I was hoping it was going to happen by tomorrow, but it looks like it's going to be next week for us to meet with the ADS and the CMHCs to have that done.

We're already working on the second half of that, which was the next 10 percent for state fiscal year '24. If -- you know, in the meantime, depending on when rates get -- you know, things get approved with the rate study and then that final, actual, permanent adjustment of the rates will happen, we will start communicating as soon as -- as soon as I have the information to communicate, we'll start having meetings.

We'll likely have a -- both a provider

and a participant webinar to answer questions when we know when we're going to be able to kind of move forward with the permanent changes.

There's more we have to do with the permanent changes because we'll have to update the regulations, and we have to update all of the waivers with CMS, so all six of the waivers.

But we are -- you know, in looking forward to that happening, we're already in the process of modifying those and doing the drafts. So it won't take us as long to move that forward.

CHAIR BEAUREGARD: Okay.

MR. CAMPBELL/INTERPRETER: He said -- Arthur said thank you.

MS. SMITH: You're welcome, Arthur.

CHAIR BEAUREGARD: Yeah. Thanks for those updates. Arthur, did you have any follow-up questions? Did that cover everything?

MR. CAMPBELL: Yeah.

CHAIR BEAUREGARD: Okay. Great. That's always nice.

Any other updates that you want to share, Pam? Well, of course, we have the PACE program rollout next.

MS. SMITH: So I will -- one other thing that we're going to do with the HCB that I just -- I had to do a -- which hopefully will be our last Appendix K modification for that second 20 percent, to be able to use the ARPA funds for that. But one thing that we also included in that was the ability to expand the support broker service to other case managers to try to relieve some of the issues with people not being able to do participant-directed services because of not having -- the ADS or the CMHCs not having the staff to do the support broker service.

So that's something -- we'll send communication out about that as soon as I get word back from CMS on that approval. But, that, I think, is something exciting because it'll expand that.

And then we're moving forward with -- and this may be later in the agenda, but I'll go on and update now because I know Arthur

wants to know about this, too. Moving forward with bundling the cost for those preemployment screenings, bundling that in with the rate, either within the FM -- within the FMA rate or, as an alternative, looking at goods and services to -- so that it's not the participant or their future employee that is paying for those -- those costs.

And, Brenda, it's home and community-based services.

MS. MANNINO: Okay. Thank you.

MS. SMITH: You're welcome.

MR. CAMPBELL/INTERPRETER: He was going to ask about --

MS. SMITH: See, Arthur, I'm on your wavelength.

MR. CAMPBELL/INTERPRETER: He said he was going to ask about that.

MS. SMITH: I knew what you were thinking today, Arthur.

CHAIR BEAUREGARD: So with that Appendix K modification that you mentioned -- you know, that's just one of the many ways that you all ask CMS to approve new things, just for folks on the phone. You said --

okay.

So you said you'd be adjusting that, so more people can do the participant-directed services. Would that be permanent, or is that --

MS. SMITH: Yes. No. We are looking for that to be permanent. It is one of the things we'll be changing in the regs so that it will operate -- all of them will operate like SCL does right now where, essentially, an individual can choose -- if they want to still choose the AD or the CMHC in their area, that'll be an option. But they could also choose any other case management agency. So that'll be a change that'll continue going forward.

CHAIR BEAUREGARD: Great. That's really great. Well, thank you.

MR. CAMPBELL/INTERPRETER: Can you email what you just -- can you email him what you just said?

MS. SMITH: Yeah. I will, Arthur. As soon as -- I want to wait and make sure I don't get any questions from CMS but then I will email -- I will email you and let you

know.

MR. CAMPBELL: Thank you.

MS. SMITH: You're welcome.

CHAIR BEAUREGARD: All right. How about the PACE program? Do you have any updates on PACE, Pam?

MS. SMITH: So yes, very exciting update. We have -- the three-way agreement between us, the provider, and CMS has been officially signed and accepted for our Jefferson County PACE provider. They -- I believe a ribbon cutting is going to happen sometime in May, but they are looking to hopefully start enrolling individuals by July. So that will be -- then we will have three providers at that point in time.

Right now, we have about 70 people the last count, and that's been a couple weeks ago that I did that count. But we had 70 active individuals being served by PACE so really looking forward to getting Jefferson County up and going.

And then we have several other providers that are in the process of submitting the paperwork to CMS, and it will be -- so

hopefully by the end of the year, we will have at least three, if not four, other providers up and enrolled by the end of this year so...

CHAIR BEAUREGARD: Thanks. And I know you've shared this before or explained this before, Pam. But PACE is an alternative program to the waivers; right?

MS. SMITH: It is. So PACE -- PACE can -- so individuals that -- that's also an alternative to institutional care, so being in a facility. The thing that's different about PACE is it kind of -- it operates more like a -- kind of a mini MCO. We pay the PACE provider capitation payments and then that PACE provider is then actually responsible for paying for and arranging all the care of the individual.

So they do all of their -- most of them have, you know, physicians or nurse practitioners on site at their PACE centers. Some of them have the pharmacies on site there. But they -- they are responsible for the -- all of the care for the individual while they are enrolled in PACE. So that's

what's a little bit different.

But it is -- it's an alternative to the home and community-based waivers if somebody else wants to -- you know, is looking for something in addition to waiver to stay out of a nursing facility.

CHAIR BEAUREGARD: Thank you. I want to catch myself sometimes because I know that with new members -- we've covered some of these items for a long time and --

MS. SMITH: Right. And I see where --

CHAIR BEAUREGARD: Throwing out acronyms and --

MS. SMITH: Right. I just -- because I thought I am talking in alphabet soup, and so thank you for the individuals that have been typing the -- been providing the abbreviations in chat so...

CHAIR BEAUREGARD: Yeah. It's a good reminder. All right. Well, that's good news to hear, that there are more providers and that individuals are being served.

Any questions about that before we move on?

(No response.)

CHAIR BEAUREGARD: Okay. All right. Let's see. The next item we have here is the Kentucky Medicaid Quality Strategy Plan, and we discussed that last month. I know that CMS approval was pending at that time, so I'm just wondering where things are at with that and also if we could just get a little bit of background to remind us of what it is.

MS. PARKER: The Medicaid Managed Care Quality Strategy is something that Medicaid is required to do at a minimum every three years. And, basically, what this quality strategy entails is focus -- what is our focus as far as quality initiatives.

The quality strategy is located on our website for anyone who wants to review that or needs some late-night reading. It is very interesting. And we did have some -- Emily participated and some others from the TAC's lead in interviewing for this quality strategy. It was submitted in November.

It's pretty much submit and use, and that's where we are with that. We have

not -- with that. We have not heard anything back so -- from CMS. And the last time in 2019 when we did a quality strategy, it took over a year before we heard back.

So I don't -- you know, there's not -- I don't think there's going to be issues with it. We may need to update it before we even get an approval from them, but we can update it as needed as well.

CHAIR BEAUREGARD: All right. Thank you. Are there any other updates about how the plan is working, any quality metrics that you're tracking that you can share?

MS. PARKER: Well, you know, with HEDIS measures, we track -- the MCOs track them all. We are looking at -- our main focus with our MCOs in 2024 based on 2022 data for childhood immunizations, well visits, maternal health, and social determinants of health, follow-up from the emergency room post being seen for SUD.

I should know all these. There's three or four others. Oh, breast cancer screening. And for right now, I can't remember the other one or two of them. But that's -- I guess --

oh, and chronic hemoglobin A1C less than nine.

So we're looking at preventive services. We're looking at maternal health, child, behavioral health, you know, the whole spectrum of issues that we try to improve upon every day.

CHAIR BEAUREGARD: Okay. That's helpful. Thanks. You know, at some point, if you've got some data to share, I think it would be great to see, you know, how things are trending over time, how some of these measures are doing. And I'm particularly interested in the childhood immunizations myself. That's an area that we've seen a decline, and it's been pretty concerning.

MS. PARKER: Yeah. That's why it's, you know, one of the main focus --

CHAIR BEAUREGARD: Yeah. I'm glad you've made that a priority measure.

MS. PARKER: And I know HEDIS is an acronym, and I cannot remember what -- it's Healthcare Effectiveness Data Information Set, I believe. But it is a common quality measurement system, for lack of the right

word, and there are several areas of quality measures within the HEDIS.

And the HEDIS season actually for the MCOs has probably ended up right now. And so they'll be calculating, getting all the data for 2022 and -- thank you, Rachel. And the final HEDIS measures will be -- we should have that by September, October for each MCO.

CHAIR BEAUREGARD: Okay. So we might be able to get -- would you have -- if you have the information by that time, could we include it on our agenda, or do you take time to compile it?

MS. PARKER: Well, if we have a meeting in October, that might be the best time. October, November.

CHAIR BEAUREGARD: Let's see. When is our -- yeah. October 17th. So I'll try to remember to put that on the agenda.

MS. PARKER: And I'll try to remember to make sure I have it.

CHAIR BEAUREGARD: All right. Well, thank you for that update. I'm guessing that y'all give us the update on the next item, too, the Hospital Rate Improvement

Program.

MS. PARKER: Yes. I mean, it's not finalized yet.

CHAIR BEAUREGARD: Okay. So there's not a report that you can share today? Okay.

MS. PARKER: Not today.

CHAIR BEAUREGARD: We'll move that to the next -- in two months, does that seem reasonable? Okay. I'm making a note to myself here. So we'll move the HRIP report to the next meeting.

And just, again, so everyone's familiar, hospitals are working with the state on certain quality measures and, as part of that sort of initiative, are getting paid the average commercial rate, which is higher than the Medicaid fee schedule.

And that was only happening with inpatient, I believe, but now there's a new law that was passed -- a bill that was passed during this legislative session, I think House Bill 75, that expands that to outpatient care.

Is that going to be something, Angie,

where all hospitals -- it applies to all outpatient care, or is it certain types of outpatient care?

MS. PARKER: That's being discussed right now on how that's going to be -- how that's going to work, so I don't know. I can't answer that at this time.

CHAIR BEAUREGARD: And I'm assuming the bill passed was to approve it, but CMS would still have to approve the plan; right?

MS. PARKER: That is correct.

CHAIR BEAUREGARD: That's not something that goes into effect immediately. Okay.

Commissioner Lee: CMS has already approved the plan.

CHAIR BEAUREGARD: Oh, CMS has already approved the plan.

Commissioner Lee: Yes.

CHAIR BEAUREGARD: Okay. All right. Well, any additional information you have at the next meeting, I think, would be helpful, just knowing how that will work with outpatient. I'm assuming outpatient, you know, services could increase with the

higher reimbursement rate.

I have been a little concerned about what the impact will be for independent providers, but I don't know if you all have been thinking about that.

Commissioner Lee: We have been thinking about that, Emily. I think that as we go forward, it's going to be really important to report out on the number of providers in each county, the number of type, so that could definitely be something that this group would be interested in and maybe encourage a report to be created.

CHAIR BEAUREGARD: That is a great idea. And thank you for joining us, Commissioner Lee. I wasn't expecting that, so it's nice to see you on.

Commissioner Lee: Well, I think the next topic on the agenda is something that I can talk about.

CHAIR BEAUREGARD: I would love to hear an update on that. Yeah. So, again, if you -- we have a new member, if you could just give a little bit of background so that we have a little more context. We get too

used to our acronyms in this meeting.

Commissioner Lee: Okay. For the community health workers and for the new member and for others, I don't think that I join this TAC very often, but I'm Lisa Lee. I am the commissioner for the Kentucky Department For Medicaid Services. I have over 20 years in with the department so have been around Medicaid and the children's health insurance program for quite some time.

But as you all know, community health workers are individuals who live and work in communities, and they are very familiar with some of the healthcare systems and the healthcare challenges that the Medicaid population face.

So in the 2022 legislative session, House Bill 525 passed that stated that by January 1st of 2023, the Department For Medicaid Services shall seek approval from CMS for services provided by community health workers to be reimbursed.

So up to this point, community health workers have been utilized in Kentucky. The Managed Care Organizations, for example --

all six Managed Care Organizations utilize community health workers in a variety of ways to help their members navigate the system and provide additional supports for those individuals related to their health care.

And the Department For Public Health certifies those community health workers, and they also have been giving some providers grants in order to utilize community health workers in Medicaid provider offices.

So by January 1st of 2023 -- we were a little bit late getting our state plan amendment in. But we had talked with legislators and had a very big workgroup, and so we did get it in in February. We got it approved in March. So our state plan amendment for community health workers has been approved.

We were set to begin services July 1st, 2023, and we chose that date because that is the beginning of a new fiscal year for us. So we are currently -- we've got our state plan amendment approved, working on our system changes. That's another reason for that July date because you've heard, I think,

Deputy Commissioner Veronica Judy-Cecil talk about unwinding, so we are going through unwinding.

We're making a lot of system changes. And unfortunately, it takes us a little while to make some changes. So we're working on system changes so that providers can bill for community health workers. Again, this service is something that has been utilized in the community, but Medicaid has not been reimbursing for it.

So beginning January 1st -- July the 1st of 2023, Medicaid providers can bill for utilization of community health workers. We are working on our regulation. Once that regulation is completed, it will be out for public comment. And we will -- we'll get some other comments on that.

As far as community health workers go, the service must be ordered by a physician, a physician assistant, nurse practitioner, certified nurse midwife, or a dentist.

We believe that including the dentists in the provider array of services is very important because we all know how important

oral health is and that it can even -- you know, poor oral health can lead to strokes. It can lead to pre-term deliveries, heart disease. So we believe that the community health workers are going to be vital in that dental population, too.

The services that they can cover -- that they can bill for include health system navigation, health promotion and coaching, and health and education training. We are going to have three different codes that the providers can bill for, and the codes are based on the number of individuals that that community health worker is educating or providing services to.

We, again, have three different codes. The first code will be billed if they are seeing just one patient. The second code will be billed if they're seeing from two to four patients, and then that third code is for a group of five to eight patients. So they can educate from a minimum of one to a maximum of eight.

There will be some Q&As developed and some more information related to some of the

specific services and billing. So, for example, if a provider is currently receiving grant funds from the Department For Public Health to pay for community health workers, they're going to have to make sure that if they bill, they're not usurping those federal dollars, and they're not double billing. So we'll have to have some tracking there.

Hospitals will not be billing for community health workers. As you heard the director, Angie Parker, talking about the hospital improvement program quality measures, as part of that outpatient improvement program for hospitals and the inpatient hospital improvement, we require them to utilize community health workers in their system. And that gives them more flexibility with community health workers because providers billing Medicaid have a very prescriptive set of services.

Community health workers in hospital settings will also be able to do a wide variety of services outside of those services that we provide. We think that that's very important for community-based organizations

and for the hospitals to use them.

We also will be -- we're currently right now in the midst of our Medicaid MCO forums. And based on some feedback that we have there, we are going to modify our presentation going forward to add a few slides about community health workers, so we're getting the word out there right now.

We do talk about community health workers, but we don't go into -- in the forum the providers that can bill and the services and the rates and that sort of thing. So we're going to interject that into the forums. We have four more MCO forums, so that information will be out there. And hopefully we'll get a lot of information out to our providers and the community.

And, again, this is a joint effort with the Department For Public Health because the Department For Public Health will certify those community health workers. And once they're certified, they can go to their provider offices, and they can deliver those services. And providers can bill for services.

And this is another service that this is brand new in Kentucky Medicaid. We -- other states allow community health workers, and they do bill through Medicaid. So this is another one that we definitely want to generate a report for to see how many community health workers are across the state and the growth of their services as we move forward.

Happy to answer any questions.

CHAIR BEAUREGARD: Thank you.

MS. MANNINO: I have a question. These community health workers, what kind of education are they being required to get certified?

Commissioner Lee: So for certification, they have to be a legal U.S. resident. They have to be a resident of Kentucky or employed as a community health worker in the state. They have to be at least 18 years old. They have to complete a competency-based community health worker training or mentorship that's offered by the Department For Public Health. And they have to meet requirements established by the

Department For Public Health for certification based on relevant and verifiable community health worker experience. And their certifications will have to be renewed annually.

MS. MANNINO: So no college associate degree or anything?

Commissioner Lee: Is required, no.

MS. MANNINO: Do you see them being utilized mostly in rural areas?

Commissioner Lee: We anticipate and hope that they'll be utilized across the state, but I think the rural areas, particularly some of those areas that have challenges, for example, with broadband where individuals can't use telehealth or maybe where there's some access issues, they will definitely be able to assist those individuals with navigating that healthcare system.

MS. MANNINO: Thank you.

CHAIR BEAUREGARD: Commissioner, as you were talking about, you know, the provider having to order the service, which I know has always been the case, it just

brought a question to mind.

Would the provider have to be seeing that patient as well, or could there be just someone in the practice who says, you know, this is -- the CHW has made this connection, and the provider, just sort of as a, you know, pro forma, is ordering the service?

Commissioner Lee: You know, right off the top of my head -- and, Emily, that's a great question. Right off the top of my head, I want to say that I would think that the provider would see the patient and say, hey, we have a community health worker over here.

Now, let's -- in the -- we can talk through this, and this is some things -- you know, when the regs are published, that's some good questions.

But I'm thinking -- let's just use the dentists, for example. We know that dental providers have -- are concerned with no-shows. They say they have a high rate of no-shows.

So if an individual has scheduled a dental appointment with the dentist. They

don't show up, let's say, for example. They could potentially use that community health worker -- if the dentist orders that service, the community health worker could potentially provide outreach to that individual related to keeping your appointments and making sure that they -- they get that information.

CHAIR BEAUREGARD: Yeah. Now that's something -- I can also just follow up with you, but I think we can also make that as a comment during the reg process.

Commissioner Lee: Yeah. What constitutes a visit, you know, or do they have to first see a provider? And we'll take that back, too, and look at how the community health workers are operating in other states and see if that's a requirement.

I know that they do require those physician's orders, but do they require them to actually have that face-to-face with the physician for the physician to order it is your question.

CHAIR BEAUREGARD: That's -- exactly.

Commissioner Lee: Yeah. Okay.

CHAIR BEAUREGARD: All right. Well, thank you. That's really good information to have. Any other questions related to this?

Commissioner Lee: And if you want me to put the certification requirements in the chat, I'd be more than happy to do that.

CHAIR BEAUREGARD: Yeah. That would be great.

MS. BROWN: I've got a quick question about the -- you said hospitals will not bill for CHWs, but I didn't understand the reason why. Can you --

Commissioner Lee: Yeah. Because the hospitals -- we have special arrangements with the hospitals related to their increased reimbursement or their reimbursement improvement programs both related to inpatient and outpatient. And those programs -- those arrangements are called directed payments.

And so any time we have a directed payment policy in place, there are quality measures -- and this is a federal requirement. There are quality measures

associated with those directed payments. So the quality -- one of the quality measures in those arrangements with the hospitals is that they will utilize community health workers to help them reach their quality measures and for other purposes as they go forward.

And I don't know how many community health workers we have in the state right now. I think this is something that we'll see a ramp-up. I don't even -- I don't know if we even have -- I don't know, Emily, if you even know the number. I'd hate to guess. I know that I've heard it before, but it's not, you know, thousands of community health workers throughout the state. It's a very small number when you compare the population of the state because Kentucky covers 1.7 million individuals in the Medicaid program, which is one out of every three.

So, again, that's why it's going to be really important to kind of keep track of the services and the locations that individuals are utilizing community health workers.

CHAIR BEAUREGARD: Yeah. I get the regular emails from the Kentucky Office for

CHWs, and I think the last one I saw said about 160-some-odd certified CHWs. And that's been ticking up over, you know, the past few months.

But, of course, we have more CHWs who aren't certified in Kentucky, but it would be -- this billing and reimbursement would be limited to certified CHWs. So I really do think that we'll see a growth in CHWs. I hope that we do.

Commissioner Lee: So I think there's a question in the chat about services that they can provide. Health system navigation. For example, if an individual has -- has the need to see a specialist or a different provider other than their primary care provider, a community health worker could help them navigate that healthcare system and help them find a provider.

Health promotion and coaching. For example, how to adhere to your medications, what sort of medications you should be doing. You know, maybe healthy eating, just different things related to health -- improving the health status of that

individual, any kind of, you know, promotion or coaching that they may need.

And health education and training, which sounds a whole lot like promotion and coaching. But those are the three bullet points that are included with the regulation, and we'll spell all of that stuff out -- out later.

CHAIR BEAUREGARD: Yeah. We were talking about childhood immunization rates earlier, and I feel like having more CHWs would also be a great way to connect with families and help them to, you know, get back into clinics for their well child checks and things like that so...

Commissioner Lee: That would be an example of health promotion and coaching. And then along with that, you know, they could -- it's the education piece about, you know, coaching you. But the education piece would go along that way. You know, immunizations really do assist children in staying healthy and the importance of them so...

CHAIR BEAUREGARD: All right.

Well, thanks for that, and we'll keep an eye out for the regulation.

The next item that we have here is the value-added benefits side-by-side. Now, this is something we discussed briefly on our last call. And we talked a little bit about, you know, the fact that some of the services seem to be actually covered services, and others seem to be value-added services.

And I just feel like there's some confusion and inconsistency between what the MCOs had on that side-by-side. So is there a way that we can make it a little more uniform?

MS. PARKER: I'm actually working with the MCOs to get it a little more uniform so...

CHAIR BEAUREGARD: Great. Thank you.

MS. PARKER: Once we get all that information for you, we'll pass it along. I'll give it to Erin and then she can pass it along, and we'll probably put it on our website, too. We haven't done that yet so...

CHAIR BEAUREGARD: It's not on the

website?

MS. PARKER: No, not with the behavioral health.

CHAIR BEAUREGARD: It was -- right, right, right. That one was created at the request of the Behavioral Health TAC.

MS. PARKER: Yes.

CHAIR BEAUREGARD: And you shared it with TAC members but not with the general public. Okay. Or with Medicaid enrollees.

So then related to that, we also talked about how helpful it would be to have kind of a supplementary guide to go along with it since, of course, you're working with a small amount of space. Is that something you're also working on?

MS. PARKER: Yes. Now, it won't be on that -- I don't know how we're going to do it on the side-by-side, if we can do it --

CHAIR BEAUREGARD: Oh, no. Supplementary to me is like it could be as many words as it needs to be in a totally separate document.

MS. PARKER: It probably will be a separate document.

CHAIR BEAUREGARD: Yeah. Because having a side-by-side that's short is really helpful whenever you're wanting to hand it out to somebody. But if people ask questions, if you have a place that you can reference for additional details, I think that would be really helpful.

MS. PARKER: Currently --

MS. JUDE: Emily, this is Victoria with Anthem Medicaid. I did want to let you know that while we're submitting the information, the additional details, I know we do have guidelines around, like, the approval processes and stuff as well.

So what we're going to -- what I'm working on is actually updating our flyer so it has more details to support that that can be distributed. But this would probably be more of an FYI educational for the TAC.

CHAIR BEAUREGARD: Okay. Yeah. That would be helpful to see. Thank you. And, you know, any MCOs, that kind of additional detail would be great. So any questions about that or --

MS. PARKER: We're working on all

that information.

CHAIR BEAUREGARD: -- any other discussion? Angie, were you going to say something else?

MS. PARKER: I was just saying the MCOs are -- all of them are working on that with us --

CHAIR BEAUREGARD: With you.

MS. PARKER: -- and the supplementary and should have soon.

A value-added benefit. All right. Who has a question -- someone has a question on value-added benefits.

CHAIR BEAUREGARD: Tia, do you want to un-mute and ask your question or just put it in the chat? Why don't you go ahead and put it in the chat, and we will get to it whenever you have a chance to post it there.

I think we can move on to network adequacy, which is again something that we've talked about before. But on our last call, I think you had mentioned a number of reports that the MCOs share with DMS, and I was just wondering if we could get some examples of those reports.

MS. PARKER: We can probably do that. I was looking to see if Jeremy Armstrong Derossett was on the line or not. He -- someone -- his staff does the oversight of all the MCO reports that come in, but let us take that back to see what we could potentially provide.

CHAIR BEAUREGARD: Thanks. I think it'll just help us have a little more context into what's being kind of tracked and reported.

And one area of clarification. I think you had mentioned a complaint form if I got -- if I got it right in my notes. The contract compliance branch has a complaint form, which I did find. You can click on the agenda. I put a hyperlink in there to make sure that it was the right form. And you had suggested that a Medicaid member could use that form to report a violation of network adequacy.

But when I looked at the form, again, if it's the right one, it just -- it didn't seem like it would be the appropriate form. And I'm not sure that somebody would know how to

fill it out, you know, related to a violation of network adequacy. So I just wanted to make sure that I had found the right form.

MS. PARKER: Probably not. I probably told you incorrectly but can certainly -- because that is -- it is strictly a provider complaint form that you --

CHAIR BEAUREGARD: Okay.

MS. PARKER: -- probably located. And I think there is a web- -- I mean, an email address that can be used, but let me -- let us go back with that, so we can get you -- make sure you have the correct information.

CHAIR BEAUREGARD: Yeah. Thank you. That would be helpful.

Any other questions about network adequacy? I do see that Tia has put a question in the chat about the side-by-side or the value-added benefits.

MS. PARKER: Okay. Doing a direct callout for behavioral health value-add on the side-or-side, or are we creating a whole separate document for behavioral health

services covered?

This was something that was done for the Behavioral Health TAC a few months ago. I can't remember exactly when. But they wanted the -- what value-added benefits and what certain behavioral health services were covered per MCO. Some of those behavioral health services that are on this side-by-side could be value-add, or they could just be behavioral health services. Does that answer your question?

We're looking at making sure the side-by-side highlights what is a value-add for behavioral health and then a summary page additional, if I'm understanding Emily and the TAC's request, of what a member has to do in order to obtain a value-add benefit.

CHAIR BEAUREGARD: You know, I -- I think for -- my understanding is that we have two side-by-sides; right? And then the supplementary guide, I would want to actually describe any of the benefits on either side-by-side so...

MS. PARKER: Correct. That is correct. There are two side-by-sides, not to

keep confusing things.

CHAIR BEAUREGARD: Two side-by-sides.

MS. PARKER: One that was developed for open enrollment last fall or actually last August/September that was strictly value-added benefits. Then there was a second side-by-side that included behavioral health services, which can also be a value-added benefit. So that's what this separate value-add behavioral health side-by-side is about.

And the TAC would like what a member/patient needs to do for any of these value-added services; correct? Yes?

CHAIR BEAUREGARD: Yes. Thank you.

MS. PARKER: Okay. All right. That's what I understand. I want to make sure, and that's what I'm gathering.

CHAIR BEAUREGARD: And I think it looks like that answered Tia's question. Everybody else clear on the value-added benefits? Okay. Great.

I mean, I think -- it's just -- it's something that we'd really like to promote.

And so having, you know, good information to put in people's hands is always helpful, so we appreciate your work on it.

Let's see. We talked about network adequacy. Was there another comment?

MR. ARMSTRONG: So yes. This is Jeremy with DMS, and I apologize. I was having just a little bit of technical issue getting off of mute.

So just want to get a little bit of clarification, too, also on this topic of network adequacy because I had thought the ask was specific to the provider -- the provider side. So if the provider was wanting to file a complaint with the department as it relates to network adequacy, that is what -- the information was provided. And the complaint form that is attached on the link would be appropriate specific for the provider.

So if we're going to discuss as far as the avenue of submission for a member, we do have an email box that is monitored within the contract monitoring branch that even though the email box naming has provider in

it, the members can also outsource to this box for any concerns relating to network adequacy, a complaint against an MCO for denial of services, anything relating to the MCOs. And members can also utilize this email box to bring awareness to the state of those issues.

So I can put the email box in the chat for everyone but just wanted to clarify, too, that for any provider complaints associated to network adequacy or even not associated to network adequacy -- so it's just a provider complaint in general against our MCOs -- that that would be the appropriate complaint form for them to utilize as --

CHAIR BEAUREGARD: The provider would be making the complaint?

MR. ARMSTRONG: Yes.

CHAIR BEAUREGARD: Right.

MR. ARMSTRONG: But yes. For the provider, they can utilize that complaint form.

CHAIR BEAUREGARD: Okay. So --

MR. ARMSTRONG: The provider complaint form itself is a little bit driven

to being claim specific. However, there is a comment section that providers can fill out to provide the details of what the described issue that they are encountering.

CHAIR BEAUREGARD: Okay. All right. And then the email box, you said, is titled as provider MCO inquiry. Do you have anywhere on the website or in the handbook that says Medicaid participants should be using that for one reason or another?

MR. ARMSTRONG: I don't think that is published as a member-facing material, no.

CHAIR BEAUREGARD: Okay. So it may be good to have maybe a separate inbox if you were going to use that as a regular way of somebody making a complaint.

MR. ARMSTRONG: Well, now, you know, member complaints can come from just about any and everywhere. So, you know, we don't surely want to tell a member you can only complain to this one avenue of source. So, you know, we do deal with member complaints through the constituent side of senator representatives.

So I'm not sure as far as the department publicizing a specific email box for members, but I believe that is something I can take away and get confirmation of appropriateness for members to utilize which source of avenue to --

CHAIR BEAUREGARD: I think -- I mean, the avenue, of course, or having multiple avenues is important because that's going to be more accessible for people. But I think it's more important even to have a -- for members to understand what they can complain about and to who when they can direct a particular complaint.

And the way I understand network adequacy right now and the reason that it's been a concern for us is that, you know, the appeal process is internal with the MCO and the -- kind of the solution provided to -- you know, if you don't get out-of-network care approved, you're told that you can switch MCOs.

But I can imagine just many scenarios in which a person doesn't want to switch MCOs because of other providers that they see.

And, you know, you also can't guarantee when you switch MCOs that that MCO is going to necessarily cover that provider or even -- or, you know, they might cover that provider when you make the switch, but there could be a contract issue and then the provider is no longer participating.

So it just -- it feels like that's a difficult way for someone to end up, you know, getting to the provider that they need to get to.

So it looks like you've dropped another inbox into the chat, the DMS web.

MR. ARMSTRONG: So --

CHAIR BEAUREGARD: So for me, I think it's more about how people -- how Medicaid members would understand, you know, what their rights are and what they can do to resolve an issue.

All right. Any other questions or comments related to network adequacy?

(No response.)

CHAIR BEAUREGARD: All right. We can move to our new business items, and there is nothing probably on the agenda there.

I've made a few comments on mine because there have been a few things that have come up since making that agenda.

Miranda mentioned to me yesterday an issue that one of her clients was having with the pharmacy formulary. I thought we could clear that up if you wanted to describe that issue a little bit, Miranda.

MS. BROWN: Yes. So a client is enrolled in Medicaid. The MCO is Humana specifically. And they stopped covering her IVIG medication, which is -- the brand name is Gammagard. And it's for -- let me look up the site. It was for her condition. It's primary immunodeficiency, or PI, specifically classified as common variable immunodeficiency or nonfamilial hypogammaglobulinemia.

Anyway, she's not able to access her medication, and this would be a problem with any MCO, as far as I understand, because it's not listed in the formulary that they all share. She's been on this medication for many years. I think she said ten years, maybe longer. And she has a disability, you

know, and this is really essential medication for her to live a normal life.

And so this is a major issue, and she's worked through the appeal process through the MCO, but yeah. It's very concerning that this isn't included in the formulary, and I'm wondering what else to do to help her.

CHAIR BEAUREGARD: I know that MCOs can cover drugs that are not on the formulary but that the uniform formulary is meant to be the standard. You know, if it's on the single formulary, all MCOs have to cover it, but that doesn't stop an MCO from covering it above the formulary; is that correct?

MS. PARKER: If you're talking about drugs, Dr. Fatima Ali, our director of pharmacy -- I don't know if she's on here or not. But, you know, MedImpact -- for those drugs that are prescribed and they are received at a pharmacy, MedImpact is the pharmacy benefit manager that reviews and approves.

Now, the MCOs are the physician-administered drugs. So if they get -- if there's a provider who gets a drug

in the office that requires PA, they would manage that part.

CHAIR BEAUREGARD: I see.

MS. PARKER: Now, if any of the MCOs do -- that are on the call can provide any additional clarity to that, please feel free to --

MR. DEARINGER: And this is Justin Dearinger. You're correct when you say that they have a minimum amount or a minimum of what they have to cover, what they're required to cover. But they can always cover above and beyond, and many of the --

CHAIR BEAUREGARD: All right. Thank you, Justin. I'm not sure if you cut out or if you were done. But that's good to know, that they can cover something in addition to the formulary.

Any MCOs want to weigh in on what that process looks like, if a patient, you know, needs a particular drug? Do they -- are they going through the pharmacy benefit manager, or should they be reaching out to somebody at the MCO to get that approved?

(No response.)

CHAIR BEAUREGARD: Miranda, maybe you can put the medication in the chat. Oh, perfect. Thanks. We're also wondering if there is a particular MCO that, you know, is already approving this medication and could make a move.

DR. THERIOT: This is Dr. Theriot. That drug is a physician-administered drug, and so the MCOs would be the ones that would do that. And they have criteria. You know, so you don't -- you can't use it for anything. It's very specific criteria of what you're allowed to use it for.

CHAIR BEAUREGARD: Okay. Well, that's good to know. But if this patient is being told that it's denied by their current MCO, I'm assuming that would be a reason that they could change MCOs for cause.

But how would they be able to find out if another MCO would approve it?

DR. THERIOT: That, I'm not sure.

MS. PARKER: They would have to contact the MCO's member services to see whether or not they could get that information from them. Of course, they

might -- you know, it's one thing to contact the MCO and say do you cover XYZ drug, but they're going to need clinical information to determine that, so I'm --

MR. DEARINGER: Yeah. That's correct, Angie. We just had a -- or I just had a case about two weeks ago where the patient had a -- or the member had a drug that they were on that -- or that was being prescribed to them and then they no longer had access to.

And when we, you know, took kind of a deep dive into it, the MCO that they were on covered that drug. But what their new physician had diagnosed them with, the FDA didn't cover that drug for that specific diagnosis. And so their old physician had diagnosed them with -- or had prescribed the drug for a different diagnosis, which was covered by the FDA, so that's why it was approved at that point.

And so what they had to do then was to go back to their physician to get a different diagnosis, which they were having trouble doing. And so then they -- you know, I think

they ended up having to go to a different physician.

So sometimes, you know, you get pretty deep in the weeds on some of those things and some of the reasons why. It's not really just as simple as do they cover this drug or do they cover, you know, this code. Sometimes you have to look at the -- what it was prescribed for, what the diagnosis was, and all those different things as well.

CHAIR BEAUREGARD: Yeah. I mean, that's kind of what worries me about this particular situation because you wouldn't be able to change an MCO really and know that they're going to cover it, that you would get, you know, a different result.

Do you think somebody at DMS would be able to assist someone in this position in kind of figuring that out?

MS. PARKER: Well, I would say that the first thing is not to consider moving to a different MCO but --

CHAIR BEAUREGARD: I mean, the appeal has been, like, in process four months and denied, so she's in a pretty bad

situation right now.

MR. DEARINGER: If you can email me the information, I just -- like I said, I just did one, so I'd be happy to go through it again.

CHAIR BEAUREGARD: And, Dr. Theriot, were you starting to say something?

DR. THERIOT: I was going to be cautious about switching MCOs for that reason because it might not be covered on any of the MCOs. Because they have to -- all the MCOs have to cover medically necessary services.

So if you have a condition and it says, in this case, IVIG is medically necessary to treat this condition, they have to treat it. But if you've been misdiagnosed or if, for some reason, you were getting this particular medicine and it wasn't approved, you know, and somehow you were getting it, like Justin said, for a different reason, and now you're not going to be able to get it at all.

And those are some of the safeguards in the system, that, you know, we want to provide medically necessary treatment, but it

has to be for the right diagnosis.

CHAIR BEAUREGARD: Right. Yeah. And, of course, having those guidelines is important. I think in this case, she was receiving it, covered by this MCO, and is no longer receiving it and has just been told that it's because it's not covered by the formulary. And it sounds like that may not be the right --

DR. THERIOT: Right.

CHAIR BEAUREGARD: -- reason. And the fact that she's done everything she can internally to appeal. You know, she's not been told that she has another avenue to appeal this outside of the MCO. And I think that's where -- you know, just similar to the network adequacy issue, you know, you don't always know if you switch MCOs that you're going to get to the right provider.

And in this case, you don't know if you switch MCOs that you're going to get this medication approved. But there's only an internal appeal process. There's not a way for that patient or the Medicaid member to go directly to DMS for some sort of resolution.

MS. PARKER: There is -- they need a state fair hearing.

CHAIR BEAUREGARD: I'm sorry. What was that?

MR. ARMSTRONG: I was going to say -- this is Jeremy with DMS. So you're stating something that's incorrect here. You're stating that there's no level of appeal rights for a member from the internal MCO appeal level when actually there is. So within the internal MCO appeal decision letter should be the member's rights for a state fair hearing. So that is their avenue for the member when they do not agree with an MCO decision, and that should be clearly stated in all MCO appeal decision letters.

CHAIR BEAUREGARD: Okay.

MR. ARMSTRONG: So I want to make sure that that is corrected.

CHAIR BEAUREGARD: I think her understanding was that she could do nothing else. You know, that was the way -- her takeaway.

MR. ARMSTRONG: Okay.

CHAIR BEAUREGARD: So -- but thank

you for reminding us that there is a state fair hearing process, and I don't know if she received that letter and understood that or not. But her -- her understanding from whatever -- whoever she has been in contact with and the process that she's gone through is that there's just no option. But it sounds like we can send details to Justin, so we appreciate that.

MR. ARMSTRONG: And whoever is sharing that detail with Justin, if you don't care to "cc" me as well since it does involve one of our MCOs, I would appreciate that. Thank you.

MS. BROWN: Can you put your email in the chat?

MR. ARMSTRONG: Absolutely.

CHAIR BEAUREGARD: All right. Thanks, Jeremy.

Something else I just -- really -- I know that Commissioner Lee is no longer on and Veronica isn't either, so we might not have anyone from DMS who can speak to this. But I mainly wanted to make sure all of our TAC members know that there are new

regulations out for dental, vision, and hearing. So if you heard during the legislative session that those services were ended by the legislature, there are new regs out, and we're in a public comment period now.

I don't know if there's anyone on from DMS who wants to say anything about that, but I just don't want people to think that those services --

MR. DEARINGER: I can talk about that a little bit.

CHAIR BEAUREGARD: -- aren't available anymore.

MR. DEARINGER: So yeah, I can talk about that a little bit if you'd like for me to.

CHAIR BEAUREGARD: That would be great.

MR. DEARINGER: Okay. So the legislature enacted a bill. Basically, the bill was to revoke those administrative regulations that we had filed. And so we filed new administrative regulations that are different, differ in some ways than the other

ones did. They're essentially the same regulations with just some changes and variations.

There was no break in coverage, so all of our members will be able to still get the care for dental, vision, and hearing that they have since January 1st. None of that went away. All those things are exactly the same. What we did do is we added some -- actually added some benefits and increased some limitations that we previously had.

We previously had included the choice for the provider to either prescribe glasses or contacts. But the contacts they could prescribe were kind of an annual -- it was either annual or every six-month -- I can't remember -- contact that had to be cleaned and was only used in specific instances.

So in the new vision regulations, we expand that to disposable contacts, and I can't remember off the top of my head if they're -- they're, like, the weekly ones or something like that. So -- but they're disposables, so there's that option.

We also increased the benefit for frames

for eyeglasses. That benefit was enhanced as some of the frames that we were providing were not very durable. They were kind of a cheaper frame that weren't lasting as long as we needed them to.

On the hearing part, we actually added some different types of hearing aid batteries and then we expanded the limitations that we had to -- for replacement batteries. And, again, I don't have the regulations in front of me, but I think we basically doubled the limitations that we had put on how many batteries a member could have per year based on some of the research we had gotten back from various members and provider groups.

So those are kind of the highlights of what all we changed, very positive changes that occurred. And as of right now, you know, all those dental, hearing, and vision expansion of benefits are all still intact and still going strong.

CHAIR BEAUREGARD: Thanks for that update, and I just want to say thank you to DMS for working on that new set of regulations. I was really worried that

people were going to be losing those services, and they're such important services to people's health.

So, you know, we were so excited last year when it was announced and then to think that they were going to go away was just going to be really disappointing. So we appreciate you all continuing that work.

MR. ARMSTRONG: And just to -- this is Jeremy with DMS. And just to pick up what Justin had mentioned, we've also shared that same expression of coverage for those expanded benefits to all of our MCOs. So there should not be any of that concern as well.

CHAIR BEAUREGARD: Okay. Great. Any questions about that?

(No response.)

CHAIR BEAUREGARD: The only other thing I wanted to raise -- and this -- I guess I'll ask first, is, you know, with new members, I've never seen any orientation materials from DMS for TAC members or for MAC members. But are there any materials that exist?

MS. PARKER: For fee for service or --

CHAIR BEAUREGARD: No. For, like, MAC and TAC members, orientation.

MS. PARKER: Oh, oh, oh.

CHAIR BEAUREGARD: Just orientation to being on -- serving on the MAC or the TAC, information about, you know, the history of, you know, the MAC and TAC and a little bit of information about Medicaid and what the role is of a member.

MS. PARKER: Erin, are you aware of any?

(No response.)

MS. PARKER: Erin may be having some issues with her --

CHAIR BEAUREGARD: Yeah. I think her mic wasn't working.

MS. SHEETS: Yeah. Erin is having some difficulty, some technical issues.

CHAIR BEAUREGARD: Well, if you want to just get back to us on that. You know, I was thinking about a possible recommendation to make just so that all, you know, new members of a TAC or a MAC -- or the

MAC would have some information, some context and background to work from.

I don't know why it didn't occur to me sooner but, you know, we've been operating as a TAC now since, I think 2018. And I haven't seen any of those materials, and I try to have conversations with new members. But I only know so much as well so just something to think about.

MR. CAMPBELL/INTERPRETER: Arthur said thank you for everything -- oh, for asking. Thank you for asking that because about 18 months -- about 18 months ago, he did -- about 18 months ago, I did some research. Oh, about 18 months ago, he did a research on how -- how TAC supposed to work, and you will be amazing -- you will be amazing how TAC supposed to work.

CHAIR BEAUREGARD: Yeah. Okay. Well, thank you for that feedback, Arthur, and I see that Miranda and Brenda have also chimed in on the chat. So it sounds like this is a good idea.

You know, it came to me because I was actually on MAC TAC, which is on the federal

level. They advise the Center for Medicaid and Medicare Services. And they've been reaching out to state advocates and members, people who serve on, you know, state-level advisory councils doing interviews with us. And they asked me if we had anything like that, and I had to think about it. And I was like, you know, no, we don't. That's a great idea.

MS. BICKERS: Emily, can you hear me? Oh, yay. It's Erin. My microphone finally decided to work now that the meeting is close to over. I apologize. Can you run your question past me one more time? I heard background.

CHAIR BEAUREGARD: Yeah. I was asking whether there was any orientation materials that, you know, the state had created for new TAC or MAC members. I haven't seen them, but I thought, you know, perhaps they exist. Because it would just be really helpful when you have a new person join the MAC or the TAC to have some background and context.

MS. BICKERS: Not currently that

I'm aware of, but that doesn't mean that we can't put one together. So that's something I can take back and look into. I see where Miranda says something about acronyms. I have worked in Medicaid for several -- I guess over -- almost seven years now and I still don't know all of our acronyms, so that probably would be helpful.

So I will take that back, and I'll try to work on that, Kelli and I, in between all of our TACs and SPA stuff. But that is --

CHAIR BEAUREGARD: And we'd be happy to --

MS. BICKERS: -- a good idea so...

CHAIR BEAUREGARD: Yeah. Well, I'm glad you think so. I was going to say we could make it as a recommendation, but I think it would not just help our TAC but, you know, it could help all TAC members and the members of the MAC. And we'd be happy to provide input or, you know --

MS. BICKERS: Sure. If you guys want to shoot me an email with some information that you think would be helpful. Lots of times, when we get a new email, I try

to send out kind of like a welcome. Let me know if you have questions. But I never really thought about having a -- here. Here's some helpful documents that might help you in your first few meetings to figure out what's going on kind of thing. So I'm more than happy to work on that and take that back.

CHAIR BEAUREGARD: Okay. That sounds good.

MR. CAMPBELL/INTERPRETER: May he have her email? May he have her email?

CHAIR BEAUREGARD: All right. Thank you, Erin. We appreciate that. And is there anything else people want to bring up before we go to our recommendations?

(No response.)

CHAIR BEAUREGARD: I know we've covered a lot. All right. Not hearing anything, I will go ahead to recommendations. Does anyone have anything they want to put forward?

(No response.)

CHAIR BEAUREGARD: You know, one thing that I had jotted down earlier was, you

know, recommending that DMS create an orientation packet. You know, we can make that as a formal recommendation even though it sounds like that's already something that Erin is willing to work on.

And then something else that came up when Commissioner Lee was talking, a report on the impact of House Bill 75 for hospital-based outpatient providers and independent providers and then a report on the impact of House Bill 525, which is the one related to CHW reimbursement on access to CHW services. It sounded like that was something that she thought would be a good thing for us to recommend. So we could put those forward.

Is there anything else that people had in mind or any comments on those ideas?

(No response.)

CHAIR BEAUREGARD: Any objections before I make a motion? Yes, you can object to my motion. Okay.

MS. BICKERS: This is Erin really quick. As far as the -- we'll call it a TAC welcome package. You don't have to make that

a recommendation. That's something Kelli and I will take back, and we will start working on that and then just kind of have that as a moving forward. And we're happy to share that with you guys, you know, in draft form and everything as we're working on it for input.

CHAIR BEAUREGARD: Great.

MS. BICKERS: That's not something you have to -- unless you just really want to make it recommendation. That's totally fine, up to you. It's just that that is something Kelli and I agree that would be very helpful.

CHAIR BEAUREGARD: We don't necessarily have to. Sometimes it's nice, though, for DMS to have recommendations that they can say, hey, look, we've already done it.

So we'll skip that one. Brenda, were you going to say something earlier?

MS. MANNINO: No. I just think that's a good idea, to have more of an orientation for new members because a lot of the acronyms I was not familiar with.

CHAIR BEAUREGARD: And even when you know the acronym, understanding the background of a particular program is still -- you know, there's just so much. Medicaid is so big and has so many different types of eligibility and so many different types of services, it can be really overwhelming. But also just how we operate as a TAC and a MAC and what people's roles are, I think, would be helpful.

MS. MANNINO: Yes, that would. Thank you.

CHAIR BEAUREGARD: So I'm glad that that's something that you all are willing to work on.

Should I go ahead and make the two recommendations for these reports? Okay. So the first recommendation would be that DMS track and report the impact of House Bill 75 for hospital-based outpatient providers and independent providers.

Can I get a second or, I guess, get a motion to -- I'm making the motion. I need a second.

MS. MANNINO: I will second it.

CHAIR BEAUREGARD: Thank you. All in favor, say aye.

(Aye.)

CHAIR BEAUREGARD: Any opposed?

(No response.)

CHAIR BEAUREGARD: All right. Motion carries.

And then the second recommendation would be that DMS track and report the impact of House Bill 525, the impact that House Bill 525 has on access to CHW services.

So I'll make that motion. Can I get a second?

MS. MANNINO: I'll second that.

CHAIR BEAUREGARD: Thanks, Brenda. And all in favor, say aye.

(Aye.)

CHAIR BEAUREGARD: Any opposed?

(No response.)

CHAIR BEAUREGARD: All right. Motion carries.

One last call for any other recommendations.

(No response.)

CHAIR BEAUREGARD: All right. So I

think that'll do it for our recommendations for this month.

The next item on the agenda is just to confirm who's going to represent this Consumer TAC at the MAC, and that will be me.

Our next meeting -- our next Consumer TAC meeting will be June 7th. That's the updated date; right? Yes. At 1:30 p.m.

And then the next MAC meeting -- I actually didn't put the date on here, but it's the fourth Thursday of the month. And that'll be next month. So that's not very accurate, what I put there. I'm not sure why I missed that detail, but it will be May -- is it 25th? Yes. May 25th in case anybody is interested.

All right. Anything else before we adjourn?

(No response.)

CHAIR BEAUREGARD: All right. Well, then, we are adjourned. I like to say adjourned by acclamation.

So thank you all for joining us today and see you on June 7th.

(Meeting concluded at 3:24 p.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 3rd day of May, 2023.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR