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

****

Via Videoconference
March 8, 2023
Commencing at 11:01 a.m.

Shana W. Spencer, RPR, CRR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Terry Skaggs, Chair

Jay Trumbo

Janine Lehman (not present)

Adam Lewandowski

Sarah McIntosh

CHAIRMAN SKAGGS: All right. I'm going to skip the introductions unless somebody would like for everyone to be introduced. You can see on the -- on the side who is on the call.

We'll move forward to the approval of the June 22nd minutes. They were mailed out or sent out to the TAC. Are there any additions, deletions, corrections? Anything that we need to do with the minutes?

MR. JOHNSON: Terry, just one minor. I did notice on the top of page 23 that it was stated that the SPA would be, I think, approved for the next ten years. I think it should be the next two years. Small change.

CHAIRMAN SKAGGS: We'll have those -- that change reflected in the minutes. Anything else?

(No response.)

CHAIRMAN SKAGGS: Do I hear a motion to approve them as amended?

MR. TRUMBO: So moved.

CHAIRMAN SKAGGS: Motion by Jay. A second?

MR. LEWANDOWSKI: Approved.

CHAIRMAN SKAGGS: I believe that was Adam. All in favor, aye?

(Aye.)

CHAIRMAN SKAGGS: Any opposed?

(No response.)

CHAIRMAN SKAGGS: Hearing none, the minutes are approved.

Going to the agenda, the first thing on the agenda obviously is the Medicaid unwinding. I know our association has sent out a lot of information regarding the unwinding.

The billing workgroup met, I believe, last week, and the information was shared at that point in time by the commissioner. And we have sent out as much information as possible.

I was just kind of hoping that we would just have a brief outline as to time frames as -- that are happening, if somebody would like to chime in on that. If not, I'll tell you the time frames as we understand them.

Is anyone prepared to just give us

a brief overview of the unwinding?

MS. JUDY-CECIL: Sure. Hi. Good morning. This is Veronica Judy-Cecil, Deputy Commissioner for Medicaid, and --

CHAIRMAN SKAGGS: Thanks, Veronica.

MS. JUDY-CECIL: Hi. I did -- I wasn't sure if you wanted me to do the presentation for the folks that were, you know, part of that billing workgroup or not. So I'm prepared to, but it is a little longer. So that's your pleasure.

If you want me just to speak to it and not do the presentation, happy to do that, too.

CHAIRMAN SKAGGS: I'm comfortable with you just kind of giving us a summary and not going through the entire presentation.

MS. JUDY-CECIL: Okay. Sure. No problem.

So right now, we are fast approaching the start of our unwind. The Consolidated Appropriations Act of 2023, signed and put into law in December, is requiring states to restart normal eligibility enrollment processing as well as

do a redetermination of everyone that has been under the continuous coverage requirement throughout the Public Health Emergency.

The continuous coverage ends on March 31st, and so that's coming up. And each state is taking a little bit of a different approach of how they're going to unwind that renewal process.

So for Kentucky, the first renewals will take place for those who have a renewal date of May 31st, 2023. So those folks that have a renewal for May will start to receive notifications April 1st. And so notices will go out to anyone that we cannot do what's called a passive or ex parte renewal.

Our system will automatically on April 1st try to renew everyone, and that -- that includes the entire population, even those that are -- that we do a resource determination for. So it will attempt to go out and hit all of the databases that we have available to us and verify people's information.

If we're unable to verify, then

they'll drop to what we call a more active redetermination, and they'll have to take steps. For the ones that we're able to verify that they meet eligibility, they'll just automatically be renewed, and so they won't have to take any additional action. It's really great for them. You know, they'll get a notice telling them they've been renewed. Nothing further is needed.

So we're going to be focusing on those individuals that we can't do that passive or ex parte renewal for. We believe that's about 20 percent of our population. So thankfully, it's a smaller number than if we were having to do that for everyone.

But I do want to also make sure everyone understands that we're doing this over 12 months. So we have a little over 900 cases, and that's for, you know, over 1.5 million people that we'll be doing redeterminations for over the course of 12 months, so from May 2023 to April 2024.

So not everybody is going to drop off in May if we can't renew them. You know, there's -- they're spread over -- or the case

mix is spread over the entire 12 months.

We are going to provide a lot of supports to our members, and we are asking providers to help with that. But we'll be sending an email and/or text message if we have both of those modalities of communication on our system. And they'll get a notice letting them know when their renewal is and that it's coming up. That'll be about 90 days before their end date.

They'll get another notice about 15 days before their end date to -- if they need to take action and we haven't heard from them. So, for example, if we've sent a request for information and that hasn't been responded to, that person will get a notice and say, we haven't heard from you. We need to. The end of the month is coming, and you're going to be discontinued.

We do plan a lot of robust outreach through phone calling, so our Managed Care Organizations are going to reach out to their population. And then we have a plan for the fee-for-service population, to call individuals that are -- as we approach the

end of the month that haven't taken action. We're going to try to reach out to them to see -- you know, perhaps maybe they're no longer eligible and they know it, so they're not taking any action. But we want to make sure if they are likely still eligible, that they do what they need to do.

If there's anybody pending a redetermination at the end of the month, they will continue. We will not end date somebody based on a worker action, a needed worker action, so those folks should not be discontinued. We'll keep them in.

And if somebody sends us documentation about 90 days after their end date and they're able to provide us what we need and we can determine them eligible, we will reinstate them back with no gap in coverage.

So those are some of the ways that we're going to support folks. There are some stakeholder meetings coming up, and they are on our website and on our social media where you can register. There's March 16th, March 22nd, and March 27th. You know, certainly,

if you can't participate in any of those, we're going to be recording and posting that online on our website, which is MedicaidUnwinding.ky.gov, and I'll put that in the chat.

The biggest thing we're just asking people to do is to follow our social media because we're going to -- that's going to be our conduit for quick and effective communication about what's happening, especially if we're finding a trend or need to change something. That'll be the best way for us to communicate that out.

And then we'll be keeping our website updated with reports where you can monitor how the renewal process is going, how many have been renewed, how many have been terminated so that we're keeping an eye on the population and seeing, you know, who's impacted by it.

So I think that's a lot to take in on the renewals. And then just one other thing to note. So the White House did announce the end of the Public Health Emergency. That's May 11th. So a lot of the

flexibilities -- we've been under several of those -- will end on May 11th. Several of those impact our nursing facilities.

Right now, you know, the -- we'll return to the 50 percent bed reserve reimbursement. We'll no longer be able to do the 270-day per diem add-on for COVID. And we'll return to a 14-day nursing facility bed hold when -- after May 11th because that's the -- our flexibilities end with that.

So that, again, is just really kind of high-level information. Happy to take questions.

CHAIRMAN SKAGGS: And you did a really nice job with the billing workgroup the other day, and I anticipate that these three provider sessions that are coming up will -- we'll have similar information shared.

Just a couple of quick questions that I know have been asked of me. If somebody were to start a -- contract COVID and start a COVID stay, say, on the 8th or 9th of May, I'm assuming May the 11th is a hard cutoff, that they would not be able to

continue that stay; correct?

MS. JUDY-CECIL: So the additional per diem would no longer be available, yeah, come May 12th.

CHAIRMAN SKAGGS: And that was my understanding, but I wanted to verify it.

MS. JUDY-CECIL: Yeah.

CHAIRMAN SKAGGS: And then on -- I know you said that emails and texts would be sent out to the recipient or their guardian, et cetera, et cetera, and then follow-ups with phone calls and all.

Facility notifications. I think in your presentation, you indicated that there would be a way that facilities would know which of their residents are in the cycle so that they can assist those families in getting that information over to you. Can you talk about that real quick?

MS. JUDY-CECIL: Absolutely. Thank you for bringing that up. I did leave that out. So we are right now working on configuring KLOCS for you all to be able to pull a report specific to your facility that has the --

(Brief interruption.)

MS. JUDY-CECIL: Uh-oh. There we go -- that has the member's redetermination date on it. So you'll be able to track when somebody may potentially discontinue, and you -- you know, we're hoping providers -- and I didn't really elaborate on this. But we're hoping providers, when they are interacting with a Medicaid member, that they are taking that additional step to check KYHealth-Net or KLOCS to see when their renewal date is and just make sure they understand.

The other piece to that is we do have on our website some flyers you all could pull down and post just -- that talks about unwinding. You know, right now -- and you all could do the same -- is encourage members to keep their Medicaid contact information up to date.

We just want to be able to reach them and, you know, we do have trouble with returned mail and, you know, people's phone numbers change. And just having at all times the most up-to-date contact information is

going to be the best way for us to try to all help that member through the process.

CHAIRMAN SKAGGS: Are there any more questions for Veronica?

MS. JUDY-CECIL: Oh. Well, so -- yeah. Let me mention about the KLOCS reports. We are -- we're finalizing the work on that. We do plan to reach out to all the facilities and provide training. We'll post the training, if you can't attend, when we hold the webinar. And we'll help facilities understand how to -- how to go through that process.

CHAIRMAN SKAGGS: Excellent.

MS. JUDY-CECIL: So that's coming up in April.

MS. OWENS: Hi. This is Holly with Anthem Kentucky, and I was wondering -- you mentioned the KYHealth-Net. Now, did you say that that will have the member's eligibility renewal date on it? Is that something that we can check there for the members?

MS. JUDY-CECIL: Yeah, Holly. And let me mention, so we are -- we've reallocated our caseload. And so right now,

if you go in and check KYHealth-Net, the date you see in there for somebody isn't accurate.

MS. OWENS: Okay.

MS. JUDY-CECIL: So we are implementing our redistribution on May -- excuse me, March 21st. And so come March 25th, the date that you'll see in KYHealth-Net will be updated with the accurate redetermination date.

Because, you know, we've been keeping people -- some people, we just keep doing what's called a special circumstance, and we just keep moving them month to month. So you're going to see -- several people in there probably show April, and that's not true because we're not even starting our renewals until May for the May renewal date.

So thanks for that question, Holly. To clarify, at the end of the March, KYHealth-Net will reflect what somebody's redetermination date is.

MS. OWENS: Thank you so much.

MS. JUDY-CECIL: Yep.

CHAIRMAN SKAGGS: And, Veronica, one last question. Did I remember from the

billing workgroup the other day that starting April 1, any new applications to Medicaid would be under the old process?

MS. JUDY-CECIL: Pre- -- yeah. Pre-Public Health Emergency, yep. We're returning to our original rules, uh-huh.

CHAIRMAN SKAGGS: Okay. Any other questions?

MR. JOHNSON: Yeah, Terry. This is Wayne. Just one other. And, Deputy Commissioner, thanks for a great presentation to the billing workgroup. We really appreciate that. It was very informative.

And just so you know, we have yesterday sent out our member communication, the KHCF connections, which included the stakeholder meeting dates as well as the Medicaid website address, as well as all of the social media options that are out there. So I think our members have all that information handy.

But one -- one question that I wanted to ask -- and this was one of the questions that I know you are in possession of. We sent a number of questions to you for

a response. But one of the questions that was asked was the nursing facility credit balances. Individuals -- you know, because patient liability was not able to be adjusted at all, you know, Social Security increases, et cetera, and an -- increased patient payments were made.

What will happen to patients that had patient liability changes that were not entered into the system that result in credit balances in their -- in their account?

And if, for example, they were on a deviation that should have ended, the caseworker wouldn't begin the patient liability process again in the system, which results in a credit balance. Will those individuals have to spend down, go out and make a complete new application, come back in, or had you mentioned -- referenced that in our billing workgroup?

MS. JUDY-CECIL: Yeah. We're -- I'm not an eligibility person, so we are trying to formulate a clear response on that. We did get approval from CMS to extend the disregard for excess resources for the

unwinding period, for the 12-month unwinding period. And so we're trying to put that into language that you all understand so that you have that available to you. We're just -- we're just verifying all that with our eligibility folks to make sure we're all on the same page. But we did ask for that, to extend that long-term care disregard.

And so in my language, what that means is that, you know, folks would be able to pay that down and not -- spend that down and not have that affect their eligibility during the unwinding period.

MR. JOHNSON: Okay. Perfect. I appreciate that clarification. That will be -- that was one of the questions, I think, that came up multiple times, so thank you.

CHAIRMAN SKAGGS: Any other questions?

(No response.)

CHAIRMAN SKAGGS: Deputy Commissioner, we appreciate it.

MS. JUDY-CECIL: Okay. You're so welcome.

CHAIRMAN SKAGGS: Great update.

Great update.

Moving into the next section, the Section G crosswalk, I know that the current support for the RUG-III system ends on 9/30. I know that our association is doing some work on a potential or proposed crosswalk at this point in time. We're still testing at this point.

Just wanted to get an update on where we were. I know there was some mention at the last meeting about freezing the CMIs and just checking to see if there was any update at this point in time on the crosswalk and any work that might be being done on the Cabinet's part.

MR. BECHTEL: So I'll try to take that one a little bit.

CHAIRMAN SKAGGS: Thank you, Steve.

MR. BECHTEL: Yeah. Steve Bechtel, CFO for Medicaid, for those who don't know me. We -- you know, as you stated, the MDS RUGs goes through September -- or I think it was October, isn't it? No. It is September, September 30, 2023.

MS. VAIL: Yes. September 30 is

the last day on MDS.

MR. BECHTEL: And so -- so that period, that last period will be used to develop your January through March rates.

CHAIRMAN SKAGGS: Correct.

MR. BECHTEL: And so our intention -- so that we can avoid those optional state assessments, those OSAs, our intention is to freeze those rates for the April through June. And then on July 1st, we will be transitioning to PDPM.

CHAIRMAN SKAGGS: Okay.

MR. BECHTEL: Now, between -- now, as far as your question as to the crosswalk, we're still gathering data --

CHAIRMAN SKAGGS: Okay.

MR. BECHTEL: -- as of right now to model the PDPM. We understand that there will need to be some decisions to be made on CMI waits for the PDPM categories and things. Those decisions will probably not be made until we have time to gather all the data. Most likely, that won't take place until sometime this fall, around August. And then around October, we'll be working on a UPL

analysis and things.

So it's a lot of moving parts that we're working on to try to transition to the PDPM process. So -- but we will -- and I have been talking with Wayne Johnson and Jay Trumbo about this, the crosswalk of the Section G. And they provided me some ideas, and so I -- we're working with Myers and Stauffer to see what makes the most sense.

So I don't have anything really definite to tell you today or any update, but those are the ongoing information that I've got for you right now.

CHAIRMAN SKAGGS: So, basically, the plan would be to freeze it for the one quarter and -- and between now and the end of the year have something in place where January 1, we would start tracking under PDPM and set the July rates from that first quarter.

So January 1 through March 31 would set those July rates. So I guess the hope at this point in time is to have something in place by January 1 to start tracking it under the new system.

MR. BECHTEL: Correct. And, Beth -- I've asked Beth Vail -- a lot of y'all know who she is from Myers and Stauffer --

CHAIRMAN SKAGGS: I do.

MR. BECHTEL: -- to be on this call to hold me to -- to correct me if I'm saying anything wrong. But, Beth, I --

MS. VAIL: Everything is good, Steve.

MR. BECHTEL: I believe his statement was correct, but you correct me if I'm --

MS. VAIL: Yeah. I guess I just wanted to kind of jump in a little bit. I've seen a little bit of the Section G kind of -- we all know Section G goes away October 1st. But keep in mind back in October of 2020, Section GG and all the PDPM items were put on all the comprehensive and quarterly assessments, your OBRA assessments.

So the data is out there in terms of determining what the PDPM values are and what the trends are. And so everything will be good for a transition to PDPM effective

July 1 using that first quarter 2024 assessment information.

Because, you know, an assessment that's active January 1 could actually be going back not only into October but even September or -- another quarter because they can be active for an entire quarter before the other one is due.

CHAIRMAN SKAGGS: True.

MS. VAIL: I guess something to keep in mind is, you know, right now, the RUG payments are on the RUG-III 34-grouper.

CHAIRMAN SKAGGS: Right.

MS. VAIL: And at one point, you know, CMS moved to RUG-IV, which your Medicare payments are based off until PDPM. And, you know, that transition didn't happen here in Kentucky Medicaid.

And so when the PDPM nursing groups were announced, they basically took those existing 60-some RUG-IV groupers and collapsed it to the 25, removing all the rehabilitation categories. And so we're left with the 25 nursing categories to establish a case mix index. You know, and that's where

some of that analysis is going on right now.

I guess, was there anything to bring up right now about, like, this potential crosswalk and how that would work with Section G going away and just, you know, adopting the 25 nursing groups under PDPM or...

CHAIRMAN SKAGGS: I think one of our biggest concerns is the rehab categories --

MS. VAIL: Sure.

CHAIRMAN SKAGGS: -- which -- you know, the 25 nursings don't capture the rehab categories. So as you all are working toward developing yours, are the rehab categories being taken into play?

MS. VAIL: Well, when CMS developed the PDPM payment groups, you know, instead of counting the minutes and the days of therapy, it went more to, you know, diagnosis codes, what was the prior hospitalization for, to capture the needs of the residents.

So the current methodology under the Medicare system using PDPM is no longer using rehabilitation minutes and days and

those things. It's more based on the resident's diagnosis and maybe why they are entered in the nursing home. Did they get their knee replaced or hip replaced? What's that, you know, clinical picture looking like that might cause them to go into therapy and need those -- and need those extra resources.

You know, if Medicare has the various categories under PDPM -- I think it's the six. And then, you know, I think the thinking is that Medicaid would adopt, you know, the nursing category to closely correspond to what's going on today. But yeah, there's certainly some considerations to be made.

MR. BECHTEL: So, Terry, I think, you know, our next step is, you know, we'll work with you guys. If you have any thoughts or any suggestions, like you said, you know, let us know, and then we'll work with you all to see what we can do to make sure that we correctly account for all of that.

CHAIRMAN SKAGGS: Yeah. I mean, I was going to say, we've got an MDS task force that's -- you know, we've got all of our

clinical folks in it. And, you know, I would definitely want them to be participating with the folks from Myers and Stauffer and the Cabinet to develop the crosswalk as it's being, you know, moved forward for that January 1 implementation.

MR. BECHTEL: Okay.

CHAIRMAN SKAGGS: All right. Appreciate it.

MR. BECHTEL: So --

CHAIRMAN SKAGGS: Anything else from --

MR. BECHTEL: Well, let me -- let me make sure because I'm not sure who that is or how to get them involved. But, I guess, Wayne, you'll help me figure that out?

MR. JOHNSON: Yes. Yeah, we will.

MR. BECHTEL: All right. Thank you.

CHAIRMAN SKAGGS: I think Wayne is our association representative with that MDS task force.

MR. BECHTEL: Okay.

CHAIRMAN SKAGGS: Since obviously it does drive our rates, you know, it's very

much a part of our reimbursement committee process.

MR. BECHTEL: So -- and Wayne has been the one who I've been working with the most on all of this, so I don't -- I'm assuming, Wayne, that you'll be bringing in everybody that needs to be brought in on your end.

MR. JOHNSON: Yes. Correct.

MR. BECHTEL: Okay.

CHAIRMAN SKAGGS: Thank you, Steve.

MR. BECHTEL: Thank you.

CHAIRMAN SKAGGS: Thanks, Beth.

MS. VAIL: Oh, you're welcome.

CHAIRMAN SKAGGS: All right. Wayne, I'm going to toss the next one off to you. You've been working with it in the background on the guardianship inaccessible assets update. Go ahead.

MR. JOHNSON: Okay. Wayne Johnson again with the association.

We had a meeting with the Department For Aging and Independent Living, Commissioner Elridge, back early February. And this issue has been -- we've raised this

issue with the Nursing Facility TAC on a couple of occasions, and we were bringing it back up with Commissioner Elridge.

And she, in that meeting, indicated she would follow up with the Department For Medicaid Services -- I don't know if that meant Commissioner Lee or Deputy Commissioner Cecil -- but to determine where our request is on treating guardianship residents differently when assets are deemed and what's -- what are referred to as excluded resources doing -- due to being inaccessible.

So our understanding is excluded resources are assets that aren't counted in the Medicaid eligibility determination because they are inaccessible, primarily. Some resources are excluded for a limited amount of time while others may be excluded entirely.

We're just inquiring again where this stands with the Department For Medicaid Services as well as the Department For Aging and Independent Living because our guardianship residents are truly incapacitated individuals. And we are, as we

have been, especially over the past couple of years, been having issues with just getting the needed documentation to prove that they are Medicaid eligible.

So it's just really more of an inquiry to where this currently stands. And I don't know if Deputy Commissioner Cecil could speak to this or who, but we're just wanting to find out.

MS. SHEETS: Deputy Commissioner Cecil had to drop for another meeting. Is there anyone else on from Medicaid who could speak to this?

MS. SMITH: Hey, Kelli. It's Pam. I can't -- I can't speak to it, but I will take it back and find out. I have not -- Commissioner Elridge has not spoken with me, or I have not been in any meetings. But that doesn't mean that that hasn't happened, so let me -- I'll take that back and find out.

CHAIRMAN SKAGGS: I appreciate that. Anything else there?

MR. JOHNSON: That's all I have, Terry.

CHAIRMAN SKAGGS: All right. We

have a guest today. Dr. Babar is with us for the polypharmacy report and for the report on hospital medications upon discharge. And if he -- I can't see everyone's name on the little panel to the side.

I'm assuming Dr. Babar is on. And if so, I will turn the meeting over to him.

DR. BABAR: Yes. Terry, I am on, and along with me is Dr. Reyna Vangilder. She is deputy director for pharmacy services. So we're going to make a short presentation.

The whole idea was we wanted to get your input that -- regarding our polypharmacy initiative and wanted to have our collective wisdom guide us in a way that -- some of the hurdles that -- which we have faced and wanted to share our journey.

I saw Betsy's name is with us on the callers, and KHCF starts with Betsy. And my other friend, Vivian, part of these discussions, and they've been really helpful to us.

So, Dr. Vangilder, would you kindly make our quick, short presentation?

DR. VANGILDER: Hi. Is it okay if

I share my screen?

MS. SHEETS: Yes. I've made you cohost.

DR. VANGILDER: Thank you. Please let me know if you are able to see the presentation.

CHAIRMAN SKAGGS: I can see it.

DR. VANGILDER: All righty.

So good afternoon, everyone. We're here to talk about the Kentucky Medicaid Polypharmacy Initiative and just kind of where we are and where we've been with this project and some of the hurdles that we've faced.

So just as a friendly reminder, the short-term goal of this is to gain insight from stakeholders on the successes and challenges of deprescribing medication with structured interviews. So we have developed a series of questions.

We are trying to outreach to -- to our healthcare team that would be most actively involved to get different vantage points from the medical director, the nursing director, or assistant director of nursing,

midlevel practitioners that may be involved, and the consultant pharmacist.

Our long-term goal really here is to establish a collaboration, a free statewide resource for LTC facilities and staff to promote deprescribing among our Kentuckians. So this is solely a collaborative partnership to improve the lives of our Kentuckians residing in LTCs. We are not looking to develop any type of penalizing policy.

So just a summary of the information being collected. Just standard processes just to kind of give you an update on what we're trying to collect. Any type of standard deprescribing processes that may exist in your facility; successes and challenges that staff experiences with deprescribing efforts; the clinical benefit and how that's weighed, especially when adding to treat medications of another side effect -- adding on a medication that may treat a side effect as well as evaluating the clinical need for adding back any type of therapy after discontinuation. Any type of

collaborative deprescribing involving specialists or other providers external to the facility.

And we know we have a racial disparities initiative here within the department so just any type of, you know, racial inequities that we might be seeing that we can help address with medication management in the nursing home. That could be with the members or with families. And any idea on how DMS can further this collaborative effort.

So our current progress. We obtained IRB approval both with UK, University of Kentucky, and CHFS in October of 2022. We defined our study population using the OIG license directory and those classified as a nursing facility.

We did electronic outreach by public-facing portals or email addresses with kind of a template letter. And I needed to update the statistic. We have actually contacted 25 percent of the facilities that qualify as our inclusion criteria without success of participation. So we're coming

into some hurdles.

Some issues that we've heard about, maybe like the legal structure that may -- you know, for some of the larger nursing homes, they might not be as easy -- you know, there's going to be levels that need to have this project evaluated. And I know Dr. Babar is working internally with his nursing home, Signature, to try to see if we can engage them.

We're unable to directly contact specific persons of interest without public-facing information. This is the concept of cold calling. It's just an IRB kind of regulation. And we do have limited manpower for study recoupment.

So it is just Dr. Babar and I primarily doing these outreaches. So, you know, this is something that we're doing in addition to other tasks within our scope of our job. So we're trying to figure out how we can be efficient and also help you all as well.

So we do want to help you all with these deprescribing efforts, and if you have

any suggestions on ideas for modifying our recruitment efforts, we are certainly open to that. And another idea we had potentially engaged in was possibly transitioning this study design to an online survey. Would that be more easy and effective?

So I'd just kind of like to open the floor to anyone who would like to provide us with some feedback, so thank you all very much.

CHAIRMAN SKAGGS: Wayne, based on the information -- I guess, Wayne or Betsy. I see Betsy there now that I can see everyone. I mean, is this information something that survey -- our survey and regulatory committee could take -- you know, take into consideration, review, and possibly, you know, make recommendations or, you know, see how facilities can participate?

I mean, I can understand from the legal aspect with the facilities some of the roadblocks that they're running into. And, you know, I'm not sure I have any other input other than is there a committee within our organization that could take a look at it and

see if there's ways that we could, you know, help or encourage our facilities to participate.

MR. JOHNSON: Yeah. My understanding, Terry, is Lisa Biddle-Puffer has communicated multiple times with Dr. Babar. But yeah, that is something that I think is ongoing, and I believe it has been raised previously within the regulatory committee.

CHAIRMAN SKAGGS: Okay.

MR. JOHNSON: But I also wanted to bring up one of the things -- when we were talking to Dr. Babar about including this, the polypharmacy agenda topic on the Nursing Facility TAC meeting as one of the agenda items, is we also asked that time be given to address the prevalence of hospital medications upon discharge to nursing facility providers and how the Department For Medicaid Services might be able to assist in communicating this issue to acute care providers, you know, simply due to the fact that, you know, polypharmacy issue -- you know, the prevalence is many times due to,

you know, acute care discharges.

So I wanted to just raise that issue. I don't know if now is the proper time or not but did want to make sure that we address that as well.

CHAIRMAN SKAGGS: Okay.

DR. BABAR: So this is -- this question is part of the agenda. And so, Wayne, first, to your point, you know, I -- I am with DMS as a consultant and then I have my own clinical practice. So what I have seen out there, that there is, within the facilities, that there's -- that we don't have an environment of collaboration, that there is always fear, and there are concerns.

When I thought about polypharmacy, I was hoping that we would bring a sense of collaboration that it's not we are putting another regulation out there, that we all together -- because our goal is common, to take care of others, we will come up with that.

But unfortunately, our healthcare system is broken, and we are a part of that broken system. We -- I can understand the

concern of facilities because, especially in our commonwealth, that we are really in an environment there -- litigation and frivolous lawsuits are so common here that we don't want to leave any room that -- because the facilities have -- barely, they have room to breathe right now.

I -- within Signature -- I know Signature is not part of KHCF or (inaudible), but I -- they have their own research committee. And I have approached to their compliance department, and they have forwarded my request to their research committee, and I'm still waiting for them. I had also approached to Trilogy and forwarded to them.

But in this discussion, the only -- if you guys get a chance to look at our questions, that these are just -- these are anonymous surveys. These questions are just very benign questions just to the point that -- tried to bring the attention of our stakeholders, our leaders of our facilities to this issue, and then for us to understand that -- how can we be helpful in facilitating

that.

So I don't know if the survey committee or this regulation committee -- it's very difficult, but I don't know how can we gain this trust. But if you guys can help us out, I really appreciate that.

And I wholeheartedly agree that polypharmacy is not just an LTC issue. Polypharmacy is a huge issue. And there are so many pieces to this puzzle which start from patient's primary care physician, goes to the hospital providers, and then to the LTC provider. And then patients and families also share some of their burden that some of them are very happy to -- and trigger happy to have medicine initiated and push this cycle.

Hospitals -- COVID pandemic stopped our efforts, but we were -- in Louisville, we were actively meeting with -- through KYMDA, Kentucky Medical Director Associations. We had an active engagement within the -- with the hospitals for med reconciliation forms on discharge.

And on which our main issue was --

and the hospital, actually, they are well-oriented. COVID stopped our progress, but medicine is like, let's get Lovenox, a DVT prophylaxis they are starting, and a lot of times, they don't stop that. GI prophylaxis, Protonix, they don't stop that. A lot of times, they start antipsychotic, which is a big battle for us within the facilities. And they start that medicine. They use it as PRN. They don't stop it and put us in a bind there.

So I think if you guys can -- being new to DMS, if the TAC can guide us how DMS can assist proactively in that, we -- reaching out to the hospitals from the platform of DMS, we will be open to that. And I would definitely try my best to seek their attention to assist us in reducing polypharmacy because one extra medicine leads to another medicine. And then polypharmacy in the end leads to increased hospitalizations at times.

So their mutual interest is aligned with our common interest as well. Thank you.

CHAIRMAN SKAGGS: Thank you.

MS. JOHNSON: Terry, do you mind if I just respond?

CHAIRMAN SKAGGS: Please, Betsy.

MS. JOHNSON: And I apologize. I was double-booked, so I had Lisa Biddle-Puffer cover another meeting for me at this time. So -- because she does have the information about where we are in this. I do know she brought it before the survey and regulatory committee.

And, Dr. Babar, I know you understand the issues that our skilled nursing facilities deal with, and I wholeheartedly agree that collaboration should happen. But, unfortunately, you know, we always feel like we have a target on our backs and not the support unfortunately that we deserve from the Government.

So I will promise I'll touch base with Lisa and see where we are. We are having a board meeting next Thursday, so I will try to get that raised as well to see collectively what our board thinks about this issue.

But unfortunately, I think the

times that we've raised it, the response we get is: Well, what about the hospitals? Because, again, we tend to have a target on our back, which is unfortunate and reduces the ability to collaborate.

But I promise you that I will follow up on this issue, and we will attempt to get a response and work with you on this important matter.

DR. BABAR: Thank you so much, Betsy. You have always been very helpful. And, Lisa, you've been part of our meetings with us, and I truly appreciate your servant leadership.

And we will -- I will talk to Commissioner Lee and Deputy Commissioner Veronica. And I will try to see that -- if there is a platform where we can engage hospitals on this issue, we will definitely do that. Thank you so much.

CHAIRMAN SKAGGS: Thank you.

All right. Are there any other issues that need to come before the TAC today?

(No response.)

CHAIRMAN SKAGGS: Hearing none, our next meeting is scheduled for June 14th. Notices, I think, have already been sent out or at least the links. And if there's no other issues or no other discussion, we will stand adjourned. Thank you for attending.

MR. TRUMBO: Thank you.

(Meeting concluded at 11:47 a.m.)

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C E R T I F I C A T E

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

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

Dated this 23rd day of March, 2023.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR