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

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Via Videoconference
September 7, 2023
Commencing at 10:01 a.m.

Shana W. Spencer, RPR, CRR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Patrick Merritt, Chair

Stephanie Moore

Dennis Fouch

Barry Martin

Michael Hill

P R O C E E D I N G S

CHAIRMAN MERRITT: I'd like to welcome everybody to the Primary Care TAC committee meeting.

We'll start off -- just to give a brief reminder for -- as to why and how the TAC committee is created. The members are appointed by the Kentucky Primary Care Association with the purpose of representing the perspective and interest of Kentucky's FQHCs, look-alikes, and rural health centers. I was asked to give a brief overview of, you know, why this was created and how it's created.

But we'll go ahead and get started by establishing a quorum.

Barry Martin, are you in attendance?

(No response.)

CHAIRMAN MERRITT: No response from Barry.

Okay. Dennis Fouch?

MR. FOUCH: Present.

CHAIRMAN MERRITT: Michael Hill?

MR. HILL: Present.

CHAIRMAN MERRITT: Stephanie Moore?

MS. MOORE: Present.

CHAIRMAN MERRITT: And I'm Patrick Merritt. I'm present as well. Good deal.

Has everyone received a copy of -- or should have received a copy of the previous meeting minutes. Are there any questions pertaining to the minutes? If not, I will need a first and a second to approve the minutes.

MR. HILL: I'll make a first.

MS. MOORE: Second.

CHAIRMAN MERRITT: Who was that? I apologize.

MR. HILL: Michael on the first.

CHAIRMAN MERRITT: Okay. And, Stephanie, were you second?

MS. MOORE: I was, yes.

CHAIRMAN MERRITT: Thank you so much.

I apologize, guys. Here we go. Let's see here. Okay. So under old business, we do have a few items that Senior Deputy Commissioner has asked to push back further into the agenda. One of those items being requested is the new update on the wind-down

process redeterminations. We can table these and go ahead and move to the new business aspects until she is available, if everyone is okay with that.

So we'll proceed to new business for now. Under new business, I know that -- it says new business from DMS. Veronica Cecil, Deputy Senior Commissioner, will give an update. She'll fill us in when she gets back with that.

From there, we'll move to update from KPCA. Dr. Stephen Houghland, can you and Molly proceed with giving an update on that?

DR. HOUGHLAND: Sorry about that. I was struggling with coming off mute.

CHAIRMAN MERRITT: You're good.

DR. HOUGHLAND: And let me just pull up something real fast. I apologize. In order to find my unmute button, I had to minimize something. There's nothing like best laid plans; correct?

CHAIRMAN MERRITT: Yeah. Absolutely. It's all right. I was trapped. I had audio coming out of one speaker and my microphone coming off the laptop, so I

understand.

DR. HOUGHLAND: Here we go. All right. So -- and during these -- well, some updates for sure. We wanted to use a portion of this meeting that we haven't, I think, historically -- the association hasn't necessarily presented to the Technical Advisory Committee and to also allow some of the public to hear some of the things that are -- that have been going on within the association representing the Federally Qualified Health Centers and the rural health clinics in Kentucky.

We do have sets of priorities and goals, and a lot line up with the goals of HRSA in support of the Federally Qualified Health Centers. And some of the things that are really important to -- to the organizations are things that may not kind of catch the public's attention necessarily, things like addressing the HIV epidemic and having programs in place to address prevention, screening, and treatment of HIV within our clinics.

There -- access to care and creating

access points and maintaining those are other areas of interest at the federal level as well as within the association that we work to support.

Another piece is promoting success in value-based care. And that's where a lot of interest has been placed, and it lines up with what the Cabinet also has as an interest, in improving participation and performance in value-based care in Kentucky. And the members of the association are very active in that.

And just as an update for -- for this group -- the members are very aware, but some of the others in the audience may not be -- is that there has been a creation of a new clinically-integrated network to help promote value-based care for members of the association in network that have chosen to participate in that. But beyond the network, there are ongoing efforts to promote value-based care broadly within the association.

We also -- in an effort to help promote practice transformation, embracing

informatics and data analytics, we've undertaken a project to bring on board a new data aggregator that will be able to ingest information from the participants within the network as well as bring in information from the third-party payers so that we can create a different set of metadata that we're able to use to help inform care and process improvement for participants within the association.

And to that, I think it would be -- one of the things that I think we found could be helpful is knowing what we know and shining a light on it but then that helps us identify things that we don't know. And, you know, we have a -- we're getting a better understanding of what our performance is within our own members, but how does that compare?

And so looking at that -- working with the third-party payers, the Medicaid Managed Care Organizations, to see how the performance of our clinics are compared to their larger networks within the state. But then there's still a bit of a gap in: How

does that kind of form up with how the performance is across all payers and all members in Kentucky? Not at a patient level but at the deidentified macro level, so we can see -- you know, these are areas where there's opportunity and where there may not be.

And so just to -- I guess one type of example of that is if we see that one of our hospital -- one of our -- the hospitals that many of our patients are seen at has a readmission rate of X, or actually has an X number of readmissions, but not knowing what that is compared to others, it's hard to know: Is that something that is a clinic opportunity, or is that something that's broader that needs to be addressed?

Because, you know, one group going to try to have a -- to have a conversation based on their performance versus something that's being seen across the board is very -- it's a very different conversation to have.

So if we are able to get information that is at the population level for all of Medicaid, that gives us a different point of

reference and allows us to understand really more clearly: Is this an opportunity for us to work on?

And so some of the things, I think, that would -- that I would suggest to the committee members that are helpful for -- for us to look at in general are things around pharmacy utilization and more specifically the number of unique utilizers and what that trend has been over a period of 12-24 months.

The number of scrips per utilizer. Because sometimes you see that it is -- that there's a growing amount of utilization in polypharmacy within individuals that are receiving pharmacotherapeutics. Sometimes it's the absolute number of people getting prescriptions. But understanding, you know, why you're seeing the number of prescriptions increase is helpful.

And that's not -- the fact that people are getting more prescriptions is not necessarily a bad thing. It's just trying to understand and seeing what the trend is and how that feeds into what is utilization in other -- in other components of the total

healthcare experience.

Medical utilization. Some of the things, I think, that are really interesting for us as we think about how we demonstrate that there's improvement in care are looking at potentially avoidable readmissions and then ambulatory-sensitive conditions, things that could be treated on the outpatient basis rather than going to a high-acuity service.

Looking at admissions per thousand and seeing what those trends are as well as readmissions per thousand.

And something that I think we are really interested in at the association level is patient engagement. And so one of the measures of that is: What percentage of patients are not seen in a 12 or 24-hour period? Those are things that we are tracking and starting to track more internally. It would be nice to have an understanding of what the total population in Medicaid experience is related to that.

And then you can filter that further by saying those that have not been seen by a primary care provider but have been seen at

an emergency room, an immediate care center, or received a hospital-based service or some other specialty service.

Behavioral health utilization is fairly similar. I think that one of the things that kind of add into that is the seven-day follow-up, which is a fairly common measure related to NCQA and HEDIS. What percentage of people have actually made a -- kept a follow-up appointment within seven days?

And then another area that I think would be really helpful for us as we think about more integrated care models is: What does oral health utilization look like at the global level, and what is happening with network development? Again, those are things that we know for our network and our association members, but we don't really have as good of an understanding about what's happening outside of our environment.

And those are just some things that we are looking at and then if we could get these additional points of data, that really gives us a broader view to help with planning.

And with that, I will pause, see if --

if Molly has anything that she would like to add around some of the other broad goals for the association and priorities, especially related to our work with HRSA.

MS. LEWIS: Yeah. Thanks, Dr. Houghland. I really appreciate it. I don't have anything prepared, but I think you covered most of it. I've just been thinking a lot about how we operate in systems, and there's a lot of overlap between the different factors or programs that impact our patients and so -- or your patients.

So I think that it's a really valuable time that we have with Medicaid to talk about these big picture issues and how we're going to help improve patient outcomes. And I think that that's a little bit about what Dr. Houghland was getting to, is that when there's a business problem that's keeping you all or is creating a miscommunication or a problem for our members and making it difficult for them to participate in the Medicaid program, that's one thing.

And we provide technical assistance for that. It's not always appropriate to talk

about that in this form, but we do have resources and are working to help eliminate or reduce that from happening, and we've found Medicaid to be a really good partner there.

I think that what we're working on to help kind of change the culture of this meeting is, like, where can we come together for an hour, you know, every other month and start to think about what the -- what the big barriers are and how we can eliminate them to work in a more either -- like, in a -- work better so that our systems are speaking to one another and are operating so that we can focus on the patients. So thank you all for that, and I really appreciate it.

CHAIRMAN MERRITT: Yeah. That was a great -- Dr. Stephen Houghland, thank you so much. That was a great update. And, Molly, thank you. It's really exciting to be at the KPCA and see some of these movements, to see these integrations of these data analytics. You know, I guess these programs evolving and being implemented allows the entire state to look at -- that data is very

useful but also to -- kind of like what Molly said, working with HRSA from an FQ standpoint.

You know, for us, for instance, having that data, shifting to the newer UDS+ models and things of that nature and looking at our target populations. Giving us the tools and the power to be able to do that necessarily wouldn't be easy if it was just a standalone, you know, health center.

So the PCA has really done a great job at pulling everyone together and creating an avenue to allow hopefully all health centers treat, you know, these underserved populations more efficiently and more effectively.

Let's see here. What's next on the agenda? Wrap payment topics. It looks like there is -- the item is pending process for historical reconciliation. From my understanding, there's still -- let me see. One second here. We're still lacking a resolution in that area.

Is there anyone that can give update as to where we're at on that? And I know Senior

Deputy Commissioner, I don't believe she --

MS. BICKERS: She's not on yet, and I believe that was one of the items she asked, wrap payment topics.

CHAIRMAN MERRITT: Okay.

MR. ELLIS: I can probably add some to that. This is Herb with Humana. I know that we are one of the MCOs, I believe, tied to that.

But we've done a big push with -- on this particular issue with voids and resubmissions of new originals that are -- and we've met with several groups, New Vista and several others, where they're starting to see large correct wrap payments coming in now.

So this is -- one of the issues, I know, was tied to some COB indicators on the claims that were showing these claims as being crossovers when they weren't. So I know for Humana at least, we've done almost all of these to get them corrected. And now the impacted providers should start seeing the wrap payments come back in.

CHAIRMAN MERRITT: Thank you so

much. And we can go ahead and pause on that, if we need to, until Senior Deputy Commissioner arrives. If you don't care, Stephanie, I may have you chime in when she comes back or does arrive so that we can talk about maybe some of the statistics that you do have.

So it looks like the next item on the agenda would be considerations for respiratory virus vaccines. Dr. Stephen Houghland, this is definitely in your wheelhouse, if you wouldn't care to maybe chime in on that one.

DR. HOUGHLAND: Thank you. And it's pretty timely because, actually, there was -- I'm not sure how many people were able to participate in a webinar that was held by the Department of Public Health yesterday that addressed some of these topics.

I think the intention behind this was to, one, solicit some feedback in programming but then also to have the opportunity to ask representatives from the Department and the Cabinet how they would envision some of the interplay and crossover between the timing of

the vaccine administrations.

So I don't want to bore everyone, but you've probably seen that there has been a new adult RSV vaccine that has been approved for people over the age of 60 and especially those that are higher risk. And so this is a new thing that could be administered to adults.

And then we have the influenza season and the -- kind of the background endemic levels of COVID with -- now that it appears to be peaking a little bit and how -- the timing of the vaccines, what is becoming available, and then also some of the questions related to COVID vaccines now that the Public Health Emergency has -- has wound down.

And the availability of the vaccine is shifting from federal programs to a portion of it being available through federal programs through VFC and a bridge program, but then also a portion of it is being handled through private pay and private insurance. And the -- and the commercialization is a term that's being used

a lot related to that.

And then layered on top it is -- right now, as I understand, there's not firm guidance from the FDA about how the vaccines can be administered as far as timing or crossover for the new COVID vaccines and what has been -- previously been administered to people.

So we don't want to get -- I don't want to get too confused on the science of it, but I think the timing related to the vaccines is, I think, important. And to me, it seems like there's also been a little bit of confusing language being used around the influenza vaccine in particular and for the timing.

So in general, the recommendation has been to delay influenza vaccines until a little bit later into the -- into the fall so that immunity is conferred throughout the season when the prevalence starts picking up. It seems like some of the direct consumer marketing has suggested that go ahead and get vaccinated now.

And I'd appreciate Dr. Theriot or others

weighing in here. But it seems like the standard is still if you do not believe that someone is likely to come back in to get a vaccine, then yes, take that opportunity. But if possible, it's probably better to wait until it's likely to be protective through the higher prevalence in that it -- currently, it seems like it's still going to be appropriate to give COVID and influenza vaccine concomitantly, or at the same time, but the RSV vaccine probably should not be.

And so one of the strategies I've seen recommended from public health officials is you have a patient over the age of 60 or pregnant women -- I forgot that -- that comes in. Go ahead and give the -- I'm sorry. Go ahead and give the RSV vaccine and then bring them back at a later time for the influenza vaccine and the COVID vaccine if they're due for a booster, or they need to have another shot. So the timing of this gets a little confusing for people.

And I guess the other question I have is beyond the conversation with DPH yesterday, are there plans for broad communication to

the provider networks with recommendations for both the -- the administration cycle and ways of obtaining the vaccine if they are interested in that?

Dr. Theriot or someone from the Department, any thoughts? I'm sorry to put you on the spot.

DR. THERIOT: No. No problem. I think we are talking about different ways of getting, you know, the word out to folks. We haven't talked about a specific notice around the respiratory vaccines. But overall, you know, vaccines need some help.

And I agree completely with what you said, about holding off until close -- you know, to further on down into the fall but -- to better cover people throughout the season. But we should. I think that's a great idea.

MS. MOORE: I do think, Dr. Houghland, that you're correct in the sense that there is a lot of confusion between the messages that the patients are receiving but I think even, you know, confusion on the part of providers. So I would agree that sort of an official DPH

statement regarding ideal timing would be really helpful.

And, unfortunately, you know, I know our vaccines arrive -- and we've actually already received our VFC vaccines for peds for flu. That probably is something that needs to be addressed relatively quickly because people's vaccine will start arriving. And once it gets in a clinic, people are anxious to give it.

CHAIRMAN MERRITT: Dr. Stephen Houghland, anything else?

DR. HOUGHLAND: Yeah. I'm sorry. Unfortunately, I do agree. I think there is confusion amongst the provider group. And some of the things that I've seen in the press have actually come from clinicians saying, you know, come in and get your flu shot now.

You're seeing, you know, retail pharmacies that are doing it. Not to throw them under the bus, but you see that. I mean, they're advertising for people to come in and get their vaccines today.

And, again, I think for some people,

that's the right answer. But by and large, it's generally not. It really should -- at this time, should -- I believe that all the guidance suggests that it should be provided to those people who you're not going to see again. You reliably predict that you're not going to see them again, so you take that opportunity.

But, otherwise, you need to wait until you can get them back in and ensure that they're going to be protected through the greatest prevalence of infection and illness. And then also for -- for those at highest risk, that it needs to be high dose. And a lot of people don't seem to be aware of that so...

And not to put words in anyone's mouths, but, you know, maybe at the time when we get to -- when you get to considering recommendations to the Medicaid Advisory Committee, maybe this could be a recommendation that, you know, consistent and more -- more directive messaging, which is likely in development, but just supporting that idea would make -- would make sense.

CHAIRMAN MERRITT: Good deal. Thank you, Dr. Houghland. It looks like the next item on the agenda is a clarification of ultimate accountability when a MCO subcontracts a line of business to a third party. I know that Molly and Dr. Stephen said that they felt like they could address this.

Molly, did you guys have something to interject on this point?

MS. LEWIS: Yeah. We're just encountering -- we've just had kind of a constant issue with working together with -- when the Managed Care Organization, like, by name of who the patients are assigned to isn't necessarily the provider also of dental or behavioral health services where the responsibility lies in terms of as in an agent or a subcontractee of the Managed Care Organization.

We just get kind of -- it takes a while to get into the rhythm of what the expectation is for each particular provider or each particular payer. So if one subcontracts out for dental with -- like,

who's going to do the credentialing? How are -- who's going to chase -- make sure the claims are being paid? Where the management level is.

So we were just kind of asking for some help with the standards of who we need to refer to because then it turns from six MCOs to, like, 11 or 12 when we have to deal with all the subcontractees.

MR. IRBY: Molly, this is Greg over at United. I appreciate that question. We use subcontractors for a few functions. A lot of our subcontractors are within the umbrella of our larger parent organization.

But I think I can speak for -- I know I can speak for myself. I can probably speak for the others. The MCOs are primarily responsible for the delegation of services, and we are ultimately accountable for the performance of those services by our subcontractors. So that's a contractual standard between the MCOs and DMS.

It's something that I take really seriously. I've got a vendor manager on my team who really works to make sure that our

vendor processes are working well. So I think the right answer is we are -- the MCOs are responsible for the subcontractor's performance, and it is not the expectation that you are overseeing performance for all of our subs.

So if you've got a problem with our subs that you need to address, I am 100 percent open to hearing about that. I know we've got our meetings on a routine cadence where we can address those things, but that is definitely something that we take personal responsibility on.

MS. BASHAM: Hey, Molly. Nicole Basham from Passport. I will just echo what Greg said. You know, we are ultimately responsible for the performance, interactions, and complaints on our -- on our vendors. And so if you've got some specific issues that are arising, we can certainly connect and see how we can get those addressed.

DR. HOUGHLAND: Patrick --

DR. MOYER: I'm just echoing that for Humana as well. Same here.

DR. HOUGHLAND: Patrick, if you wouldn't mind me adding a little bit to what Molly has said?

CHAIRMAN MERRITT: Yeah. Absolutely.

DR. HOUGHLAND: And I appreciate the feedback from Greg, Dr. Moyer, and Nicole. And I would say that it is not consistent. However, there has been some trends that kind of flow -- ebb and flow a little bit around how third-party subcontractors have been treated.

I do understand it is the expectation in the contracts that the ultimate responsibility lies with those that hold the contract directly with the Cabinet in the state. I would say that it's not unusual to hear that, well, you need to talk with a third party to address issues with contracting, credentialing, file loading, et cetera.

And, for example, we have individual contracts with third-party administrators for benefits only because they have a contract with the payer, not because they have a

contract with the State. And so the actual legal relationship is, then, between the provider and that outsourced third-party vendor.

So I just bring this up, that it does sometimes come down to a question of who has the legal responsibility or not. But -- and I think from our perspective, ultimately, the only reason they are here is because of an overriding contract. But it does create sometimes points of confusion for providers, not just for our providers but I think more broadly with providers. And it's something that I would --

MS. BASHAM: So, Steve --

DR. HOUGHLAND: -- recommend.

MS. BASHAM: This is Nicole at Passport. I think we've talked briefly about this. Some of these vendors, especially, you know, dental and vision, have their own networks. And so yes, your contract, if you had one, would be with them to participate in their networks.

However, what I'd say is if you have issues, we need to see those. We need to

know about those. We have an expectation that they are performing as we would perform. And if they're not, we need to address that with them, you know.

There's going to be issues and problems, and we need to make sure that, you know, we're addressing those timely and getting those resolved for you. And so I know that we've got a few challenges sometimes around those, and we've talked about those briefly. But happy to have another conversation to see if there's other things that can be addressed.

DR. HOUGHLAND: Sure. No. I appreciate that, Nicole. And this is really not directed at any particular organization. It's more of a global thing to bring up, is that it is confusing to maintain multiple networks.

And I think it's just a point of conversation and something that I think that the -- that everybody needs to be aware of, that it doesn't always operate the way people think it is and that just -- and also that it is, I think, all of our understanding that

ultimately the responsible parties are those that are contracted with the Cabinet.

MS. PARKER: And this is Angie with Medicaid. Yes, I can confirm that the MCOs are responsible for all their subcontractors. And if you are having issues, then please get with them. And if you cannot get them resolved, you can -- there is a process to contact the Cab- -- or Medicaid.

MR. IRBY: And, Dr. Houghland and Molly, I think the message that we're hearing -- or that I'm hearing is there are opportunities to make sure that you've got the right points of contact amongst the MCOs. And so we'll follow up offline just to make sure that you feel like you have that.

But yes, we want to make sure that your ability to navigate our big system is simple, and so I'm taking that message out. I think there's a formal answer to yes, we are responsible, and then there's a practical answer to let's make sure that we make that an easy process. So I'll follow up with you separately.

CHAIRMAN MERRITT: Good deal, Greg.

Thank you. Yeah. I was going to ask if that process is clear and concise. Being fairly new to this, I definitely think it's -- a lot of times, I hear a lot of processes being talked about, but clarification on those processes are always important.

Any update on Senior Deputy Commissioner and her arrival time?

MS. BICKERS: She has not logged in yet.

CHAIRMAN MERRITT: Okay.

MR. IRBY: If you'd like, I feel like I am able to give an update about the OB ultrasound encounter submission project.

DR. HOUGHLAND: Sure.

MR. IRBY: I participate in a workgroup with all the MCOs about wrap payments, and so we talk about this really frequently and better understanding what we can do to make sure that you all are receiving your wrap payments.

And so this particular item has come up in a few calls, and I believe that UnitedHealthcare is the only one who has yet to be complete with this. And so I hate to

say that out loud, but I'm the transparent one in the group.

So to the best of my knowledge, all of the other MCOs, they are on their follow-up care appointments. They may not be sending you a payment. However, they are sending those claims on a paid file to the Department. That way, you're eligible for wrap payments.

We are working through an IT project. It is in-flight right now. It took a little while to get it prioritized across other projects that were impacting similar clinics. So we are working through that project right now to make sure that those visits -- while we may not pay for those because they were included in another bundled service, that they are present on the paid encounter file. That way, you're eligible for those wrap payments.

Once that project completes, then we will resubmit all of our historical items back to 1/1/21, which is when we started service, and we'll make sure that those show up on the paid encounter reports. And then

you'll have encounter -- or wrap payments flow after that.

So, again, to the best of my knowledge, I believe that UnitedHealthcare is the only one outstanding on that, but we do have the project in flight.

CHAIRMAN MERRITT: And, Greg, you said back to January 1, 2021?

MR. IRBY: That's right. Yep. That's when we started service in the commonwealth.

MS. BICKERS: Patrick, if you'd like, I believe Justin Dearinger is on and can discuss the CHW issue or topic.

CHAIRMAN MERRITT: Yeah. That would be great.

MR. DEARINGER: How are you all? My name is Justin Dearinger. I'm the acting director for the Division of Healthcare Policy.

So I see on old business, we had talked about submission of claims for CHW services in a dental setting. CHW services are up and running. Everything is going well. Everybody is billing correctly, properly

except for dentists. And so that has been an issue that we discovered actually right after we started and started actually receiving those claims and realized that the CPT codes were not working correctly.

As we were working through ways to fix that, we got lucky, and some new D codes came by -- came out in August. And so those D codes had one that was compatible with CHW services. And the only thing we are waiting on now, we are in touch with a couple of different vendors the -- for dental services that the MCOs use and making sure that the way we have proposed to use those is compatible with their systems and their software.

You know, once we get that information back, we'll send out some guidance on exactly what we're -- what we're using and how we're doing that. Basically, our proposal is that the D codes will have a modifier with them that denotes whether you're using those -- serving those CHW -- or using those CHW services for one individual or more than one individual.

I think there's three different price points, just like the CPT codes, that we'll have three different modifiers for and then those are based on 30-minute increments in the CPT codes. And because the D code doesn't break it down that way, we use those as just the number of those D codes billed. So one billing would be 30 minutes; two billings, 60 minutes and so on.

But all that information is still kind of up in the air depending on your all's systems and -- or the dental systems, I mean, and how they work and as long as we can accommodate all of that. If not, then we'll come up with a different solution.

But we should have something out very shortly. I'm hoping within the next -- at least within the next two to three weeks, we'll have a solution, and we'll have it implemented and be getting a provider letter out to all the dentists about exactly how we've taken care of that issue. That's all I've got for that so...

CHAIRMAN MERRITT: Thank you, Justin.

MR. DEARINGER: You're welcome.

MR. IRBY: Justin, this is Greg. We have an open communication with our dental vendor about this right now, too. I know the code that's being proposed is D9994, but I'm hearing you say that we are considering modifiers.

Do you know which modifiers are being proposed right now?

MR. DEARINGER: No. I don't have that exactly -- I don't have it in front of me. I know we've sent that to a couple different places for them to look at. I think they're just kind of some generic modifiers that denote -- or that kind of separate out whether that's services being used for one individual, more than one. And I -- there's three different classifications. I think there's one for, like, five to eight people and one for, like, two to four people.

But I think they're just some kind of generic modifiers that we're trying to be able to fit in. And I know the one catch point for that is that those modifiers are not allowable, I don't think, for paper

billing.

MR. IRBY: Yeah.

MR. DEARINGER: But they are allowable everywhere else and all electronic billing. So that's something that we're still kind of working through, too.

MR. IRBY: Yeah. I think with the dental form published the way that it is, I'm not sure that that would be allowed on the form, like you said. Also, our portal -- so it's an electronic submission. It's not through an 837. But our portals directly reflect the dental form as the ADA has published it, and so they -- providers couldn't use that either.

So I'm curious to know what we could do outside of modifiers. Because potentially diagnosis codes could help with that, but we don't want to falsely -- we don't use that inappropriately. So I'm curious to know if there's other solutions where we could use the procedure code without a modifier while still differentiating the types of care.

MR. DEARINGER: There are other -- yeah. So we have a couple of other solutions

if that -- you know, if we find that the majority of the dental networks and other -- can't support that, can't support the use of those modifiers, we have some thoughts on the number of codes -- number of that code billed and being able to kind of play with that.

And so that's a little more complicated, and I'd have to -- but if that's -- if that's how it has to go, then we can do that as far as the amount of code that's billed. So you billed that code four times, it means this; and you bill it six times, it means this.

So there's a way to do it that's kind of unconventional and funky, but it works. And so I would -- if that's -- that's kind of plan B.

MR. IRBY: Okay.

MR. DEARINGER: If that makes sense, and it's a little weird but...

MR. IRBY: It makes sense.

MR. DEARINGER: Yeah. Okay.

MR. IRBY: Thank you.

MR. DEARINGER: You're welcome.

CHAIRMAN MERRITT: All right, guys. So Senior Deputy Commissioner is still not

available, to my knowledge. Do we want to proceed and allow the MCOs to give their report until she hopefully becomes available?

MS. BICKERS: I just sent her a Teams. Her meeting is just ending, so she should be on hopefully soon. So if you want to go ahead and proceed until she logs in, I'll send you a message when she logs in.

CHAIRMAN MERRITT: Perfect.

DR. HOUGHLAND: And, Patrick, I'm sorry to jump in. If I could, though --

CHAIRMAN MERRITT: No. Go ahead.

DR. HOUGHLAND: -- for the group. I think -- yeah. I know, historically, the -- each of the Medicaid Managed Care Organizations have had an opportunity to present to the TAC, and I think your participation has been extremely important. And, you know, the live interaction also is helpful in understanding the issues and trying to find some solutions and then make recommendations to the Department For Medicaid Services. And we really appreciate that and want to foster that even more going forward.

At the same time, in talking with some of the members, it is felt that there may be some opportunity for some additional guidance as far as the topics that may be helpful and help move programs along further and faster.

And so moving forward, the -- one of the things that we have been asked to do is help develop some of those particular items of interest to -- for the MCOs to present to the Technical Advisory Committee.

And I think, you know, we kind of -- we have some offline avenues to help develop some of those topics through regular meetings with the association that we have all of the MCOs. So, hopefully, this won't be too much of additional work or burden for you and will help create kind of a more effective venue going forward.

The other thing that was asked of by members is that -- as part of those kind of guardrails, if you will, is having some -- a little bit of time limits so that there can be some consistency in how the presentations are given and allowing time for question and answers so that we can -- so that the agenda

can be managed a little more effectively and allow time for interaction and feedback.

And, you know, we've seen that, you know, sometimes people -- you run short on the back hour, and so one group isn't able to get the time that they deserve. It's not by any kind of design. It actually is probably by more of lack of design.

So going forward, we'd like to suggest that each MCO plan for a presentation of three to five minutes that would allow a period of time for question and answers during that. And the topics we can work on offline in advance and it be published, though, to comport with the requirements of open meeting and open records standards but -- that those would be published in advance so that everyone can prepare for a presentation to the group.

And I -- with that, I guess I'd kick it back to the committee members and see if there's other things that they would like to add or any questions for the MCOs.

MS. MOORE: I think I would just say that we want the time to be spent more

collaboratively in nature. You know, we -- most of us are receiving, you know, the monthly provider newsletters. You know, we're aware, by and large, of sort of the high-level initiatives that your organizations have going on.

What we hope is that we can use this time to be more of a dialogue about how we could collaboratively solve our shared challenges related to supporting patients.

CHAIRMAN MERRITT: Good deal. Thank you, Stephanie. Thank you, Dr. Houghland.

So I have received confirmation that Veronica has arrived. So welcome, Veronica.

SENIOR DEPUTY COMMISSIONER CECIL: Good morning. I apologize with, you know, conflicting schedule appointments, so thank you for your patience.

CHAIRMAN MERRITT: Sure. No. We understand. So we did push some of the agenda items further down the list in waiting for your attendance. Would it be okay if we went ahead and jumped back to old business on the agenda and let you address some of these

items?

SENIOR DEPUTY COMMISSIONER CECIL: Yeah. That would be great.

CHAIRMAN MERRITT: So the first item that we pushed was new updates on the wind-down process and predeterminations -- or redeterminations.

SENIOR DEPUTY COMMISSIONER CECIL: Yes. And if I can share my screen, and I'll try not to spend too much time on this but just letting you know. So we're in the fifth month of processing. We've done May, June, July, and we just went through August renewals. I don't have data to share on that yet because we're finalizing the data for our September 8th monthly report to CMS.

If you don't know, we do a monthly report to CMS to let them know what's happened during the reporting period. Those are posted on our unwinding website, so you can always go out there and see that information.

But let me just quickly keep folks -- so can you see my screen?

CHAIRMAN MERRITT: Yes, ma'am.

SENIOR DEPUTY COMMISSIONER CECIL: Okay. Great. So this just is a snapshot of Medicaid enrollment. You can see -- so this is January. Unwinding started in April. First renewals were in May, so you can see that -- the decline.

Not wholly unexpected because we knew that we were retaining individuals during the Public Health Emergency that we would have normally disenrolled due to a change in circumstance but had maintained their eligibility and continuous coverage during that time. So, you know, a lot of these folks, no longer eligible.

What we're really most concerned about is those who may still be eligible that are falling through the cracks either by not returning a notice -- so anybody who does not respond to a notice where we've requested information or verification by their renewal date, they do get terminated.

They can always come back in. There's a 90-day reconsideration period. And if they reach out after their termination and within those 90 days, we will reinstate them if

we're able to determine them eligible.

So that's what we're working on right now. And, in fact, the meeting I was attending right before this one was all about unwinding and renewals.

Again, I think we all are on the same team when it comes to making sure that eligible individuals remain covered during this unwinding period and/or move over to a Qualified Health Plan. If they are no longer eligible and they don't have other coverage through an employer or through some other way, that we're getting them enrolled in a Qualified Health Plan, so they do have some coverage.

So just looking at -- here's our July renewal data. As we reported in our monthly report, there were almost 55,000 individuals that were subject to renewal. This shows how many approved, a little over 27,000; how many were terminated, a little over 20,000.

We do have individuals pending. An individual may be pending because they've submitted documentation, and we haven't reviewed it or processed it to make a

determination. So we do have cohorts from previous months that will remain pending until that determination is made. So you'll see people pending.

The good news is we're continuing to see an increase in what are those reinstatements, so individuals that come back in after that termination and that 90-day period. We are tracking those so that we can see, you know, who might be coming back in. So these are generally people that probably were procedurally terminated but were otherwise eligible. They just didn't respond in time.

So we're track -- we're going to be tracking these back within that 90-day period. So you see 5,600 May renewals, 4,700 June renewals, 2,200 July. And just, you know, the number of folks that have come back on since the August 30th termination renewal, we've had 433 already come back on, so tracking those.

Our priorities are to make sure that households with children respond to a notice. Children's eligibility, the federal poverty level is higher, so children may still

qualify even if an adult in the household doesn't. So definitely making sure people understand the importance of returning that information. And, you know, even if the adult thinks they're not eligible, we'd still rather them respond and let us make an actual determination through that process than to just be procedurally terminated.

So responding to notices, especially if a child is in the household and then, you know, definitely reach out. Perhaps the first notice that they really paid attention to was the one that's terminated their Medicaid, or they've come into a provider's office and have discovered that their Medicaid is terminated. So, you know, just making sure members try to, in that 90-day period, respond.

So as providers, we appreciate you all being on the front lines, seeing our members every day. And as part of that, you know, you're certainly part of the team for Medicaid renewal. And we really appreciate -- some providers have been extremely proactive in trying to assist their

members.

The redetermination date is -- or renewal date is on KYHealth-Net. You have access to it. So when a member comes in, you know whether or not they have a renewal that month or the next month, or maybe it's six months. But you have access to that information.

And we just appreciate you all just asking the member about the renewal. Are they taking care of what they need to to make sure that that determination can be made or connecting them to the resources that are available to them, connectors and insurance agents all throughout the state.

Every community has a connector or insurance agent that can help that person, and they can go to -- go into their office, or they can call them for that assistance. So I just wanted to re-emphasize that.

So this is where you can find that redetermination date on KYHealth-Net when you log in. And then again, you know, just trying to encourage folks to choose that Qualified Health Plan and make that first

payment, so their coverage -- there's no gap in their coverage after they lose.

The good news with reinstatements is we're seeing it increase, but the also good news -- there is this little blurb right here. But, generally, we're seeing people who are losing Medicaid enroll in QHPs, and that's great; right? We don't want people without coverage.

Just a reminder. We do have some flexibilities that have gone past the Public -- end of the Public Health Emergency. Those are on our website. Just constantly reminding folks about the -- making sure that you have that HIPAA-compliant platform if you're doing telehealth that's required by the Office of Civil Rights.

I'm not going to go through all these, but, certainly, we'll send the slides to you.

Kentucky has taken numerous steps to -- and implemented strategies to try to make the process of renewal a little easier on our members, on our workforce. And these are strategies offered by CMS. So we are, yeah, leveraging some of those to make sure that we

are properly identifying and determining folks through the unwinding. So definitely some additional flexibilities we've implemented.

Unwinding website, if you're not familiar with it, medicaid.unwinding.ky.gov. Lots of resources including those flyers and information available for providers.

And then we do have a monthly stakeholder meeting, third Thursday of every month. It's open to everybody. So you could be a provider. You could be a member. You could be an advocate. It's the time that we allocate to provide information especially -- we go over the monthly report to CMS. We can keep people -- folks updated on what's going on with -- with the unwinding.

So that's all I've got for that and happy to take any questions.

MS. MOORE: Good morning. Could you speak a little bit to the percentage that are able to be auto renewed or whatever?

SENIOR DEPUTY COMMISSIONER CECIL: Yes. Thanks for that question. Prior to the Public Health Emergency, just for

level-setting, we had an extremely high rate for what's called ex parte or passive renewal. And that's where a member has to take no action. Our system can go out and verify the databases and get information that provides what we need to make -- to determine somebody eligible.

It was in the 80s prior to PHE. It's been quite a bit lower, and that's only because we knew that we have folks that are no longer eligible. So being able to go out and passively renew them is a challenge because we know they're not eligible.

So our rates have been down around -- anywhere from, like, 60 percent -- in the 60s. It's climbing. And I really wish I could tell you what September was, but I don't have that data yet. But in August, it was higher. It was in the 70s.

So we're ticking back up to a high rate of renewals that can be performed passively, which I think is just so much better for everybody if we're able to verify that information so they don't have to take action and they don't get procedurally terminated as

a result.

Great question, though. Thank you.

MS. MOORE: And so, like, the 54,975 in July, was that excluding those passive renewals, or that number included those?

SENIOR DEPUTY COMMISSIONER CECIL: Yeah. That's the total number of individuals that we ran through renewals in July.

MS. MOORE: Okay. Thanks.

SENIOR DEPUTY COMMISSIONER CECIL: Yeah. I apologize. I didn't have the information specific to passive and active on that, but I'm happy to get those numbers for you.

MS. MOORE: No. We just were curious about the trends, so this is plenty. Thank you.

SENIOR DEPUTY COMMISSIONER CECIL: Sure. Yeah, yeah. No problem.

And you can -- again, those monthly reports that we post on our website has how many -- each month how many have gone and been able to approve through ex parte or passive, so it's a great way to really check

that data every month.

Any other questions on unwinding?

(No response.)

SENIOR DEPUTY COMMISSIONER CECIL: Last thing is just if you all -- you're going out, and you're pulling down those resources available, the flyers, the provider FAQs, you know. If there's anything that you think you may need that's different, please reach out. You can reach out, you know, through Erin or, certainly, you're always welcome to contact me.

If there's something else we can do, you know, some kind of informational pamphlet, flyer, whatever, poster we can create for you, happy to do it because we appreciate you all helping our members through this process.

MR. HILL: Hi. This is Michael. I have a question. Is -- the data broken down by region, is that available on the website as well?

SENIOR DEPUTY COMMISSIONER CECIL: We do not -- great question. We do not yet have that but working on a report that we can -- it's going to have all demographics.

So we'll be breaking it down by age, gender, race, ethnicity, and then also by region. And we're working on that and hope to have those posted very soon.

MR. HILL: Okay. Thank you.

CHAIRMAN MERRITT: Thank you so much, Veronica.

So we'll go ahead and jump to new business. So we're going to talk about new business from DMS.

SENIOR DEPUTY COMMISSIONER CECIL: Yeah. I -- honestly, I don't have anything to add to unwinding.

I don't know if you all already talked about community health workers. You know, that implementation is ongoing. I think with any new service that we're covering, we're going to -- you know, there's going to be things we identify and have to go back and look at, but I don't -- I don't have any other updates today.

Happy to take any questions, though, if anybody wants to ask me -- it's open mic. If anybody has a question that you'd like me to respond to, I'd be happy to.

CHAIRMAN MERRITT: Dr. Houghland, did you have -- I know earlier, you kind of gave a brief overview of some of the updates from the PCA. Were there any of those that you wanted to relay to Senior Deputy Commissioner?

DR. HOUGHLAND: Oh, so I think one of the things that I did suggest, after feedback from members, that might be helpful, Senior Deputy Commissioner, was some population health -- or population utilization measures from Medicaid. And I don't know if you think that would be best formed as a recommendation from the committee or not.

But I think, you know, we -- I think I framed it as we know what we know, but how does that fit into the rest of the population? It's kind of hard. And so then, you know, are we an outlier or not? And is that something that we need to think about from a systematic viewpoint of tackling?

So if we're comporting with everyone else, okay. But if we are an outlier -- you know, we have information at the payer level,

but it still, you know, sometimes can be a little bit misleading. So we'd like to be able to see, you know, how things are looking at a high level related to, you know, common utilization measures. You know, and honestly, you know, in the strive for value, we also have to take into account what is the cost effectiveness of things as well.

So looking more at cost and utilization, medical economics and having that presented to the advisory committee so that we can also have, you know, a different opportunity to review, analyze, and potentially make some recommendations at that level so...

Nothing too unusual things that we're looking for but, you know, we can provide you with a list.

SENIOR DEPUTY COMMISSIONER CECIL: Yeah.

DR. HOUGHLAND: I don't know how you would recommend going forward, if that needs to be a formal recommendation or -- or not.

SENIOR DEPUTY COMMISSIONER CECIL: So my suggestion is if you all want to send

that to us, and we can just have an agenda item for an upcoming meeting. And, you know, Angie Parker is -- leads our Population Health and Quality division, and so we could certainly present.

I wasn't sure if you -- when you're saying, "Are we an outlier," do you mean Medicaid in general or just from your all's perspective from the providers that are part of KPCA?

DR. HOUGHLAND: Yeah. Exactly. Providers within the association, are we -- how are we performing collectively? And so then how do we create systems to make improvements?

SENIOR DEPUTY COMMISSIONER CECIL: Yeah. So I have to tell you what's really exciting about this discussion is, you know, that's what we see the value of the TACs as. And this is exactly on point. You know, what data do we need to be looking at? And working together with you all, what is it that we need to do to the program to increase access and to improve outcomes? And so I think this is a great, you know, starting

point.

And like I said, I recommend that maybe we make it an agenda item. You all can send the metrics in particular you're interested in, and we can present, you know, what we have and then start having that conversation about: Well, what are the things we can tweak?

I think I've been -- there's been discussion in the past about: Do we change the model? And by model, I mean how we reimburse FQHCs and RHCs. We are happy to continue that conversation and, you know, think of ways to change the program for the better.

We -- we have not -- and, certainly, I want to make sure people understand -- said completely no to any idea to change the model. We're open to listening and to seeing what makes sense and happy to continue those conversations about, you know, what fits for Kentucky.

So that's, I think, another area, if you all want to think about going forward, is to continue to have those conversations about:

Is the current model working? And if not, what can we do to change it?

DR. HOUGHLAND: Well, and as staff, I would say, you know, we really appreciate the dialogue that we've been having and the continued one. But it seems like, you know, understanding where we are and, you know, what is -- and where do we want to go.

Then, you know, at that point, you can start talking about: What does the model need to look like to try to get to the result? But being -- I think, you know, in your approach of being informed as we look at that seems to be the most effective way of doing it.

SENIOR DEPUTY COMMISSIONER CECIL: Totally agree, Dr. Houghland. So it does not require a recommendation. All we need is for you all to -- you know, we can handle it within the agenda in the meetings and just send us over what it is that you think you want us to look at, and we can work on presentation and discussion for a future meeting.

DR. HOUGHLAND: Thank you. You

know, we'll work -- staff will work on packaging that up and sending it to you by end of week so that there's more than enough time to understand, you know, is this --

SENIOR DEPUTY COMMISSIONER CECIL: That would be great.

DR. HOUGHLAND: Is this something that -- you know, this is not a -- this is not a couple week or a month thing for the next meeting, and maybe a little bit longer, and just kind of conditioning people for what the cycle of delivery of that information may be and what's possible and what's not.

SENIOR DEPUTY COMMISSIONER CECIL: I appreciate that. It does take some time for us to pull down data and do a quality test on it and make sure that it, you know, is accurate.

MS. PARKER: And this is Angie Parker. Please, by all means, you can work -- send this directly to me.

DR. HOUGHLAND: Okay.

MS. PARKER: As the Senior Deputy Commissioner stated, you know, this is part

of what we do and look forward to drilling down for you.

DR. HOUGHLAND: Thank you.

DR. THERIOT: It was quite the list so best to have it in writing.

DR. HOUGHLAND: Oh, we'll send it in writing. The good news is they're fairly standard things, for the most part.

CHAIRMAN MERRITT: Good deal. Anything else, Dr. Houghland, for Veronica?

DR. HOUGHLAND: I don't think so.

CHAIRMAN MERRITT: All right. Then we'll move forward to wrap payment topics. So once again in the hot seat, Senior Deputy Commissioner.

SENIOR DEPUTY COMMISSIONER CECIL: I don't think it's so hot. You guys are always quite nice.

So as some of you know that are part of our wrap workgroup -- and the workgroup has been working for several years now to try to resolve some -- what I identify as sort of systemic issues with the wrap process. We did develop some guidelines around reconciliation and have shared that with a

couple of providers just to take a look to see would this work in your all's world.

I don't know your world. I've not worked in your world, so it is important for you all to provide us feedback and let us understand what's happening.

So I think we've got some feedback for that, and I think I saw an email yesterday that has incorporated some of that feedback. And we're just, you know, making those updates and hope to get back out.

The plan is to then share that broadly with all providers and to walk through, you know, what the process is. How do you reconcile your wraps on a regular basis? What you know is you send a claim to the MCO, and what you expect is the MCO sends it to us, which is called an encounter, and that should generate a wrap.

And so we've -- you know, some great things have come out of the workgroup including a way to look into that process to see exactly what's happening. You all now -- providers and MCOs now have the ability to see what's happening with that claim and

encounter and wrap. So we've tried to provide that -- that tool.

So, you know, we'll do -- happy to do some training on it, you know, and share that more broadly. I believe this is a work in process. You know, once the providers are out there really going through it, we're going to, like anything, probably identify some unintended consequences or some things we didn't think of. So I consider this an iterative process where we appreciate feedback and will take that into consideration and see what things we can change.

I'm just going to acknowledge that I understand that there is quite a bit of a historical issue with some of the wraps and -- going back to 2014 or maybe even a little longer, and that's challenging. And the reason that's challenging is because the only way that we can pay a wrap is if we have an encounter. And the only way we have an encounter is if the claim came through the MCO, was properly processed, and then sent over to us.

So if it's a really old claim, the ability of the MCO -- because some of them, you know -- there's a couple of MCOs that have changed hands. You know, some of them might not have the ability to go back and process that.

So these are -- I think these are individual cases that we're going to have to look at at the provider level, and we stand ready to do what we can to help. But, you know, again, hopeful to get that information out to everybody very soon, and we can move -- maybe finally move forward on that reconciliation process.

I will also say -- so we did -- we did a pilot with one provider. We're about to do a pilot with another provider. I need to outreach to that provider. The reason we're doing that is, again, so we can just test the process of the system to see if it's working.

So if you're not one of those pilots, don't get disappointed. Don't feel left out. You'll have your opportunity, especially once we get the reconciliation process posted. Happy to take questions.

MS. MOORE: Yeah. Not questions as much as comments. I appreciate your acknowledgment that the historical claims are still out there. And I think it's important to mention on behalf of the other members who are on this call that, you know, for the past nine years, we've tried to work really collaboratively. Like, there's not been a time in the last nine years that we haven't been talking about wrap reconciliation.

And I think, you know, we entered into the tolling agreement. I think that we have tried to act in good faith and in cooperation, recognizing that it's complicated. But I think the dollars are real. I mean, we've done what we were supposed to do as providers. You know, we submitted the claim. We provided the service.

And so, you know, it's concerning and disappointing for there to be a -- well, we don't know what's going to happen with these historical claims. And going back and touching each claim is a really hard business proposition.

You know, if I just look at my organization from July of 2014 just through the end of calendar year '20 -- so, like, we're going to take out 2021 and 2022. But through the end of 2020, that's, you know, almost 12,000 claims and a half million dollars. You know, that's a lot of jobs I can create. That's a lot of raises that I can put in the hands of my employees. It's a lot of unreimbursed care that I can provide to patients.

And so, you know, it's really hard to sit here and just think about that amount of revenue disappearing into the wind. You know, if you add up to current, you know, it's almost two million dollars as our receivable.

And so I think that we want to work collaboratively, but I think that we're going to have some sort of process that doesn't create -- you know, at this point, I would have to add an FTE just to try to go chase those dollars. That also doesn't seem fair.

So I think that our members are going to expect us to continue to have a conversation

about those historical claims.

SENIOR DEPUTY COMMISSIONER CECIL: Fair enough.

MS. MOORE: But I -- you know, in terms of, like, current, like, it's unfortunate that we now have to build in an AR process to get paid on a wrap when, again, we've already done what we were supposed to do. But I think that that's a doable process moving forward, and I appreciate that work. I just don't want, you know, anything older than 90 days to just have to go into the wind.

CHAIRMAN MERRITT: Thank you, Stephanie.

DR. MARTIN: Veronica, this is Barry. Hey, how close are we to having this reconciliation method that we keep talking about? For people that does want to -- like Stephanie, that wants to go back and go after her claims? We were supposed to have that up and running by now, but what is the realistic time frame?

SENIOR DEPUTY COMMISSIONER CECIL: I'd say probably early next week. Again, you

know, I think it's been helpful to get -- to share it. We don't want to be putting out a process that doesn't work, so it was important, I think, to get provider input. The pilot has helped us with some more understanding about what's going on and, you know, I'm not going to let the perfect be the enemy of the good.

So I think early next week, we should be able to send something out to all the providers to get -- to get it, you know, sent out broadly and start to just then turn in to a: Well, what is it that we need to identify from that moving forward to assist providers?

Because I hope you know this really is about helping you all get what you -- you know, accurate and timely payment has always been the two goals of this process, to get to accurate and timely payment. So, you know, I don't think any of us are ever going to believe that it's going to be perfect. Claim processing is not a perfect system.

But -- and there are always -- you know, as we dig into claim examples, we find a whole host of, you know, issues that -- that

there is a shared responsibility in. You know, some are on the provider side. Some are on the MCO side, and some are on our processing side. And that's what we've been trying to identify and work through.

You know, what -- where can we educate the provider? Where can we ensure the MCO system is processing it correctly and sending it over as an encounter, and where is our system appropriately generating a wrap?

Because I'm sure you all -- again, this is your world but, you know, not every claim is eligible for wrap. And so there's a very complex way that that all gets generated in the system. And so, you know, just -- our goal is timely and accurate wrap payment.

That was a longer response than I think you wanted, Barry, but let me go back to early next week.

MS. MOORE: But can I clarify? That's the process that was reviewed at the last workgroup; right? Not --

SENIOR DEPUTY COMMISSIONER CECIL: Yes.

MS. MOORE: Not the process for

really historical claims.

SENIOR DEPUTY COMMISSIONER CECIL: The process is the same regardless of whether or not you're looking 30 days back or nine years back. The process remains the same in terms of being able to identify what claim did not generate a wrap, working with the MCO to ensure that the claim was properly processed and sent over as an encounter, and then having it generate the wrap.

So like I said, I mean, this is going to be a very provider level process. Every provider is going to be different. They're going to have different claims and different scenarios.

And what I do think is important as we work through this is when we -- when providers do start the process, if you're identifying systemic issues, is that that gets escalated through our -- we've got an email address that will be provided that providers can utilize that if you're finding systemic issues, then they should be escalated to us. And we will absolutely help with, you know, resolving -- if it's the

MCO's responsibility, you know, helping to resolve that systemic issue.

MS. MOORE: So --

DR. MARTIN: And this is going to be open to all providers?

SENIOR DEPUTY COMMISSIONER CECIL: That's correct.

DR. MARTIN: Not just the -- in the pilot but to all?

SENIOR DEPUTY COMMISSIONER CECIL: That's correct. Yep. Yep.

MS. MOORE: So the -- I will admit I am not team billing. This is not my area of expertise. I will talk about operations all day long. But on that process, the piece about getting -- doing the inquiry lookup, you know, that it -- the claim is only in KYHealth-Net for 90 days. So how do we get that information for a claim that's older than 90 days?

SENIOR DEPUTY COMMISSIONER CECIL: I -- Stephanie, I might have to take that back. Because if you're talking about the encounter thresholded?

MS. MOORE: Yes.

SENIOR DEPUTY COMMISSIONER CECIL: And so we -- it never got into our system. What then you know is that it was a problem with the MCO crossing over to the MMIS, to us. And so you need to go to that MCO and work with that MCO as to what -- why didn't that cross over? Because the MCO absolutely has that information.

MS. MOORE: Okay.

SENIOR DEPUTY COMMISSIONER CECIL: So they know why. Now, we are -- we have heard, and we are making changes to how long we keep that -- we call it a threshold. So for those of you who are not familiar, when the encounter comes over and we can't accept it for some reason, it gets put on a temporary file and then it does eventually expire. It's put on that temporary file so that within that period of time, somebody -- the MCO might be able to fix it and to make them aware of the issue and give them that opportunity.

So we are looking at changing that so that you all do have access to any encounter that could not come in that, you know, then

couldn't generate a wrap. And I don't think I have my folks on that can talk more intelligently about -- about all that, but let me take that back and make sure that we're covering that in the guidance if it's not in there.

MS. MOORE: Okay. Thank you.

DR. MARTIN: Sheila is on the call. Sheila, what is your thoughts?

SHEILA: We have -- I have notes from our wrap group meeting from January that have the MCOs only going back approximately two years to reprocess or figure out the issue on any particular claims and why they didn't wrap.

You would think that would be a long time but, obviously, you know, we've worked a lot of these claims for many years. And that window of opportunity that we're granted, we're dealing with that, and we're making leaps and bounds of progress with that. But at the same time, we have MCOs that are recouping payments after we've closed those books and taken monies back way past that two-year threshold.

So there needs to be some guidelines, I would imagine, as -- you know, these are the timelines, the framework that we're working in. And, you know, when an issue is systemic and it's getting close to those two years and it's still not resolved, we need to know that these claims are going to be recognized and processed and --

SENIOR DEPUTY COMMISSIONER CECIL: Yeah.

SHEILA: -- you know, if there's a window of opportunity for the MCO to make recoupments as necessary, then we need to be able to collect those older claims as well.

SENIOR DEPUTY COMMISSIONER CECIL: 100 percent, Sheila. I can't disagree. The two-year lookback is kind of for standard, and it ties back to a DOI, I think, regulation.

But I have made it very clear to MCOs and had specific conversations with a few of them about the need to go back historically beyond the two-year period for this process. And a lot of that stems from we know that some of the issues were on their end, and

it's not okay to walk away and say I can't go back more than two years to resolve the issue.

So I will again note for all the MCOs that are on -- and I've mentioned this in numerous meetings with their leadership -- that for FQHC and RHC wrap reconciliation, they need to be working very closely with the impacted providers on attempting to resolve whatever the issues are.

MR. ELLIS: Yeah. And I will say that Greg kind of chimed in, I think, before you joined, ma'am. And he also, I think, kind of iterated that as part of that all MCO wrap discussion. We've been all on the same page with that.

SENIOR DEPUTY COMMISSIONER CECIL: Thank you. I appreciate you mentioning that.

DR. HOUGHLAND: Patrick, if I could ask a question. And for the reporter, this is Steve Houghland.

Senior Deputy Commissioner Cecil, just out of curiosity, in the kind of fines and penalty structure of the contracts, do the threshold errors trigger any penalties for

the MCOs, or are those in other types of claims and encounter segments? Or does it count in the encounter submission side?

SENIOR DEPUTY COMMISSIONER CECIL: We do. We do have penalties for encounters that can't cross over, that generate errors.

And the other thing I want to mention. So good or bad, right or wrong, for FQHCs and RHCs, in order to encourage the MCOs to submit claims and encounters that might be aged, we have -- we are waiving the penalties for them on the timeline.

So that is our way of being able to -- for the historical process to say go and work it out. Resubmit it. You're not going to get dinged by us. You're not going to be penalized by, you know, sending over a claim that might be aged.

DR. MARTIN: I thought you had set that up in the past, that you had told us that. This is Barry.

SENIOR DEPUTY COMMISSIONER CECIL: Yeah. Its been ongoing since we've started the wrap workgroup, is to allow for that opportunity. And I have to -- I mean, MCOs

have taken advantage of this. They have sent over, you know, a large number of claims that, again, I think have generated a wrap, you know, when one is required.

DR. HOUGHLAND: Thanks for that clarity, Veronica. I just -- I wanted to put that question out there just to clarify it and also to help -- you know, for those that are also not on the call, to understand that. There are incentives in place for all groups to figure this out. It's not in the best interests over time for these threshold errors to continue for the payers as well.

SENIOR DEPUTY COMMISSIONER CECIL: Agreed.

DR. HOUGHLAND: Thank you.

DR. MARTIN: Okay. So -- Veronica, so I'm clear about this -- this is Barry. Next week sometime, you will have the methodology in place for all of the FQs and RHCs to be able to go back and start requesting claims to be reprocessed. And the MCOs are clear that they are to go back and help us with that process; right?

SENIOR DEPUTY COMMISSIONER CECIL:

That is correct.

DR. MARTIN: Okay.

SENIOR DEPUTY COMMISSIONER CECIL: I'm an attorney, so I'm going to say the caveat is if there's something I don't know. My team -- my team may be cringing. I don't know. But yes, I do not foresee any issues with us being able to -- to release that early next week.

DR. MARTIN: Okay. I think that makes us all feel better, that it's finally occurring. I mean --

SENIOR DEPUTY COMMISSIONER CECIL: And, again --

DR. MARTIN: -- you guys have done a great process. You've done great progress with us being able to do current claims. We're still having problems with dental, of course. But with current claims --

SENIOR DEPUTY COMMISSIONER CECIL: Yes. And it's being worked on.

DR. MARTIN: -- we're doing really well. It's just the past claims is now the problem that we need to finalize.

SENIOR DEPUTY COMMISSIONER CECIL:

Well, and so let me say -- you're going to hear me say this every time. We are not going to drop this policy and process and just walk away. This is going to have to be iterative. It is not going to be perfect. So let's just agree to continue the discussion and resolve those issues, you know, as we move forward.

DR. MARTIN: Well, I think we've been at the table long enough for you guys to know we're not going anywhere either until it gets resolved. And I think it's been a very collaborative effort, but it's -- now is the time to get it finalized and let us -- those of us that have claims in prior years, to process.

Is this a good time to talk about that same going back and recouping other claims, or do we have anything else to talk about in regards to the latter years' methodology? Stephanie? Patrick? Dr. Houghland?

CHAIRMAN MERRITT: Barry, were you on the call earlier when Stephanie was discussing this a little bit in detail?

DR. MARTIN: No, I wasn't, nor was

Veronica.

SENIOR DEPUTY COMMISSIONER CECIL: Well, and I'm happy to go back and listen. I generally do that, so I'm happy to go back and listen to the recording. But if you also want to just send something to us, you know, in writing, I'm happy to take a look at it because I know we're up on -- you know, starting to --

DR. MARTIN: I think it goes -- it simply just goes back, the processing. We've had times when they've gone back seven, eight years for fee adjustments, and it's causing a lot of problems. And we just recently had one, and we really need to put something in the contracts -- in the new contracts that really prohibits that.

SENIOR DEPUTY COMMISSIONER CECIL: Yeah. Those should be escalated to us to take a look at.

DR. MARTIN: Okay. Do you hear that, Sheila?

DR. HOUGHLAND: Yes. Oh, Sheila. Okay. Yeah. And I think the -- as a general comment, the more specificity internally that

we can get to the Department. And, if necessary, the DOI is very helpful. And, clearly, I guess on that particular topic, if it's been touched and how many times it's been touched. Because I think there are some regulatory things about how the clock is reset depending on how -- when it has been modified, et cetera.

And, Sheila, if you want, we can talk offline in how to package up some of that stuff and get it to the Department.

And this is Steve Houghland. Sorry.

SENIOR DEPUTY COMMISSIONER CECIL: That would be great.

SHEILA: That would be great.

SENIOR DEPUTY COMMISSIONER CECIL: Did you all get to discuss some of those specific MCO issues?

DR. HOUGHLAND: I'm sorry to interrupt, Veronica. The OB ultrasound topic, Greg Irby did give an update there and --

CHAIRMAN MERRITT: Herbert gave one on Humana, the Humana processing delay.

DR. HOUGHLAND: Yep.

SENIOR DEPUTY COMMISSIONER CECIL: Okay. Okay. Great. Well, again, I'm happy to go back, and I don't want everybody to have to rehash. So I just want to make sure they were taken care of, and I'm certainly available to continue any other conversation.

MS. MOORE: Patrick, I don't think the DentaQuest Molina issue was discussed.

CHAIRMAN MERRITT: Yeah. It was not, no. That's still one lacking.

So do we have anyone present that could discuss the DentaQuest validation project?

MS. COWHERD: This is Yolanda from Passport by Molina Healthcare. Nicole Basham, our plan vice president, she did have to drop from a call. But she did advise that leadership, we are discussing options to solve along with Legacy Passport entity, Avalanche. So we are still in the works on that.

SENIOR DEPUTY COMMISSIONER CECIL: I --

CHAIRMAN MERRITT: Is there any kind of -- I'm sorry. This is Patrick. Is there any kind of ETA or any further

specifics when that would be resolved?

MS. COWHERD: How about if I let Nicole know about that -- I don't have any information on that -- and let her weigh in on that for you?

SENIOR DEPUTY COMMISSIONER CECIL: We will also add this to the operations agenda that -- for our regular monthly meeting with Molina so that we can stay on top of what's going on with it.

MS. COWHERD: Sounds good. Thank you.

CHAIRMAN MERRITT: Thank you.

DR. HOUGHLAND: And, Patrick, this is Steve. The fourth one is a little -- it's a little vague, and so I apologize for that. But I think, just to kind of frame it, you had mentioned the thresh- -- Senior Deputy Commissioner Cecil, you had mentioned the threshold before and the use case where it is not passing through. It fails to meet the criteria.

The inverse, if there -- and, theoretically, if there is a situation where some things may cross through but it

potentially shouldn't, is there a process to notify and work those that the providers should utilize?

SENIOR DEPUTY COMMISSIONER CECIL: Yes. I put in the chat the DMS wrap questions email address. That's the email address that providers should escalate things to.

DR. HOUGHLAND: Okay.

SENIOR DEPUTY COMMISSIONER CECIL: Yep. Thank you for that. And please call me Veronica. Everyone should call me Veronica.

DR. HOUGHLAND: And then, I guess, for -- you know, to -- for clarity, if -- when should a response be expected when something goes into the mailbox?

SENIOR DEPUTY COMMISSIONER CECIL: It just depends probably. I think -- and I'll take this back. We should always acknowledge it within, I think, 24 to 48 hours, so the provider knows that it's been seen. And when we do get those, it gets put on a list and tracked. And, you know, it might involve different team members that have to come and help resolve it. So it's a

really team effort to resolve some of these.

So I'll take that back to make sure that things are being at least acknowledged. For a resolution, you know, it could just depend on the issue.

DR. HOUGHLAND: Okay. No. I appreciate that. On the clinical side, it's kind of like, you know, somebody had lab work done. If they didn't hear anything from it, they don't want to necessarily assume that it was -- everything was normal.

SENIOR DEPUTY COMMISSIONER CECIL: Right. Sure.

DR. HOUGHLAND: Thank you.

DR. MARTIN: Dr. Houghland, we -- this is Barry. We did talk about the DentaQuest issue, but have you addressed those before I got on here?

DR. HOUGHLAND: Just quickly that -- well, at least as it related to the relationship between -- the new relationship or emerging relationship between Molina and DentaQuest. That was just discussed, and I think Nicole Basham is going to provide an update and also around when an estimated time

for completion might be on that.

Our understanding is that there's a process of testing of an encounter submission, but I think we need to get more specifics. And Nicole -- it's going to be escalated to her to provide an update to us.

DR. MARTIN: Okay. I know we've had -- many of the dental providers are having problems, and they definitely don't -- they don't need to encounter any more problems than they already have.

DR. HOUGHLAND: Right.

SENIOR DEPUTY COMMISSIONER CECIL: Yeah. Barry, I also offered to put that on our operations agenda for our regular meeting with Molina.

DR. MARTIN: Okay. Thanks.

CHAIRMAN MERRITT: Good deal. Are there any further questions as it pertains to the processing delays for reconciliation items?

(No response.)

CHAIRMAN MERRITT: Good deal. We've already discussed the considerations for respiratory virus vaccines per

Dr. Stephen Houghland. Let's see. Discussed. Discussed.

Dr. Stephen Houghland, were you guys -- what was the -- I know that you gave a brief description earlier about the recommendation for MCO reports going forward.

DR. HOUGHLAND: Right.

CHAIRMAN MERRITT: The process change. Did -- is there going to be something that you were going to send? Were you recommending that we send something out to the MCOs so that they are aware of what that structure looks like going forward?

DR. HOUGHLAND: Yes. I think that was kind of the -- a kind of consensus from members offline, and so that would be the recommendation. Ultimately, the committee can decide how they want to proceed. But I think just kind of gathering recommendations from others not on the committee to have a more directed presentation on specific topics so that everyone's time, including the MCO's time, are being used more productively and that they can have the appropriate people on the call to address concerns.

Veronica, the idea is that in advance of the meeting, we would submit topics that are of interest to the committee to hear from the -- from the MCOs with, you know, some time limits but allow for a question and answer so that it's a little bit more of an interactive process.

And, you know, while we're concerned about the state of health in general, this committee's purview is really more directed to FQHCs, look-alikes, and RHCs, and so try to have the topics with that lens more than just -- than the general population.

SENIOR DEPUTY COMMISSIONER CECIL: That sounds wonderful.

MS. BICKERS: And this -- oh. Sorry, Veronica.

SENIOR DEPUTY COMMISSIONER CECIL: Go ahead.

MS. BICKERS: I was going to say -- this is Erin with the Department of Medicaid. So, usually, with our presentation requests, the TAC will -- you know, and say -- for example, this meeting, say we would like the MCOs to present on topic A, B, and C in our

next meeting and then I follow that up with a formal request with what you would like to see from them. So that gives them ample time to prepare between meetings and also have the appropriate person to present on.

If you would like a data request, you can make those data requests in the meetings, follow that up with Kelli Sheets and I in writing, and then we can actually request that data, whether it's from the MCOs or from DMS, and then we -- you know, 90 days.

So -- like Veronica spoke earlier, so that way, we can ensure the data is accurate and reviewed before sending it out. So that's typically the process the TACs have.

As far -- now, if it's just an open general discussion and you want to send out, you know, with the agenda, MCOs, if you could briefly discuss Item A, B, and C without an actual presentation, that is also an option that some of the TACs utilize depending on if you want an actual presentation to be shown or just a general discussion on certain topic items.

DR. HOUGHLAND: So I guess that

really is at the discretion of the committee members. I don't -- you know, in previous conversations, I don't know that we need to have a major glossy presentation. It's more around some of the content and driving some action out of it. And, you know, if it's limited to three to five minutes, I mean, it's generally two or three slides. But I guess that is up to the committee's desires, how they would like to move forward.

If we do need to have something for them to start thinking about and reacting to at this particular moment, if I can make a recommendation to the members that potentially some insights into what is being seen around pharmacy trends and utilization. In particular, kind of med adherence and medication possession would be helpful. Immunization results, I think, would also be something that is of interest to our members.

And one of the things that we are going to continue to -- I think within the network and the association continue to talk about are the unengaged members, and what do we need to do collectively to try to shift that

percentage from those that are not engaged to those that are now more engaged.

And that's really a collective effort that involves the providers, the payers, the Department, and the community a lot of times, to try to help get them more engaged in health care. I don't think -- by ourselves, I'm not sure that problem is going to be solved.

MS. MOORE: Yeah. I would just reenforce that. It seems like sometimes we hear all about programs about how people can get rewards. But, fundamentally, that's not what's going to motivate our patients. And so I think that we'd like to spend this time talking creatively about specific initiatives that we could develop together that, like Dr. Houghland said, might engage patients.

CHAIRMAN MERRITT: Greg?

MR. IRBY: Yeah. So I like this discussion so much. I'm wondering if we could just have a targeted discussion on this in the next meeting where we bring our quality directors into the meeting to really talk about: What are the goals we're trying

to achieve? Because I think we have a lot of overlap, the goals that we're trying to achieve, you're trying to achieve, the Department is trying to achieve. So what are the goals? What are the ideas that we have? What are the ideas that you have?

Because even just hearing the one statement saying rewards is not the motivation, that's really helpful. That's something that we may need to tweak our approach on.

So maybe in the next meeting, we could have more of a focused discussion around: Here are the goals we're trying to achieve, the health goals we're trying to achieve, and here's the collaborative discussion around how we get there. Is that something we could do?

CHAIRMAN MERRITT: Dr. H, do you have any input? I know that's kind of in the wheelhouse of what you're leaning towards.

DR. HOUGHLAND: I'm certainly game for it, whatever. I don't want to hijack this committee, though. And so I think it really is to the members to -- is that a

first step and we continue to iterate, or you continue to iterate?

CHAIRMAN MERRITT: Yeah. I mean, Greg, I think that would align very well. I think figuring out how -- it sounds like we're all traveling the same road, you know, the similar paths. We're just trying to figure out how to align those paths, so we're all working towards the same cause and on the same path.

DR. MARTIN: This is Barry. I think it goes back to us working as a team collaboratively, as partners trying to help the patients. Because some of the quality initiatives or quality rewards for the patients, some of the providers may feel like that's not the most advantageous.

So if we could work together with our ideas as providers and with the MCOs and DMS, I think that would work even better. Just, like, what we're asking for for, you know, developing the quality indicators, if we could be more in tune with that.

And something that I -- it's been remiss on my part, is we have not included our

dental staff on these wrap payment groups. And I think if we would have included them initially, these issues could have been resolved a lot quicker. So the next wrap group, we will have our dental staff there to address those issues, Veronica.

CHAIRMAN MERRITT: Good deal. Thank you, Barry.

So, Greg, you're proposing that the MCOs bring their quality directors and have a targeted discussion during the next TAC committee meeting?

MR. IRBY: And I hope every other MCO doesn't kick me under the table, but yes. I think that would be a really good and productive discussion.

CHAIRMAN MERRITT: Absolutely. I mean, I would look forward to it. I think that the committee members, you know, from our behalf on the TAC, would appreciate that and would entertain that and would be grateful to be at the table to discuss that.

MS. BICKERS: Greg, my apologies. Could you give me that title again, so I can follow up an email? Your quality directors;

is that correct?

MR. IRBY: That's right. Quality directors.

MS. BICKERS: Okay. Thank you.

MR. IRBY: Yeah, for sure.

MS. PARKER: I think that -- this is Angie Parker with Medicaid. I think that what -- if we're talking of incentives and what each MCO is offering, they're currently working on their value-added benefits side-by-side that they're to provide to the -- to us by September 15th.

That might be a starting point to kind of look at what each MCO is currently offering, and we can certainly and would be providing this information to the TAC members prior to it being posted. So I don't -- that's just a thought on how to potentially start with the conversation.

MR. IRBY: That's a good thought.

DR. MARTIN: Then, Dr. Houghland, you can get this out to all the providers, the KPCA providers, and ask for their input, so we can have something put together for the next conversation?

DR. HOUGHLAND: Yes.

CHAIRMAN MERRITT: Yeah. Angie, thank you for that information.

MS. PARKER: Now, we will be getting it from each of the MCOs and putting it all together. And so we would have -- give us a couple weeks to get it all fixed. But we certainly get that out to everyone prior to the next meeting to give you all time to review it as well before the next meeting.

CHAIRMAN MERRITT: Good deal. All right. Well, I know -- guys, I apologize for today's meeting, kind of jumping around. I know Senior Deputy Commissioner Cecil, we rely heavily on her for some of those updates, and she wasn't able to attend until later into the meeting.

I would ask -- if there are any critical MCO updates that need to be given, I would ask that we take this last ten minutes to give those. I know that we're pushing it down to the last minute. But are there any MCO updates that absolutely need to be given or, if not, at your discretion, could be

tabled until the next meeting?

(No response.)

CHAIRMAN MERRITT: Okay. Good deal. Thank you all so much.

Is there any additional other business from any of the other committee members?

DR. MARTIN: Not from me. This is Barry.

CHAIRMAN MERRITT: I think right now, the recommendation, we're going to discuss potentially population level data from DMS. But I think we discussed that previously, and we're going to forward that information per request on to you guys to get that information. So I think we're okay there.

It looks like the next meeting is scheduled for November 2nd, 2023, at 10:00 a.m. And if there's no other business, we'll need a first and second to adjourn the meeting.

DR. MARTIN: I make a motion to adjourn. This is Barry.

MS. MOORE: Hey, Barry. This is Stephanie with a question really fast.

Before you jumped on, Dr. Houghland had talked about a vaccine issue, and we had mentioned doing -- making that a formal recommendation to the MAC. Do we need to take action on that?

DR. HOUGHLAND: So, Veronica, just quickly. The conversation was around some of the confusion that seems to exist in the community around the three respiratory vaccines that are now available for adults, pregnant women, and -- being the RSV vaccine and then the influenza and the new COVID variant vaccine, the update and timing.

And so DPH had a very good webinar yesterday. I was wondering if there is any -- if you're aware or if the Department is aware of communication that's being created to go out to providers about the timing of administration of those vaccines.

There's direct consumer marketing that's kind of pushing flu vaccines right now and that, for some people, it's probably best to -- actually, for a lot of people, it's probably best to delay if they can reliably get a vaccine at a later date. So trying to

do some counter-marketing, basically.

The recommend- -- I think a loose recommendation would be that the Department consider developing educational material to be provided to providers and the community about the appropriate utilization of these respiratory vaccines.

SENIOR DEPUTY COMMISSIONER CECIL: So, generally, we do leave that up to the provider associations to make those communications about the practice of medicine. But happy to take that back, and I'll talk with Dr. Theriot and see. We don't generally make -- do education around the practice of medicine, but we can take that back.

And so you were -- you don't have to make a formal recommendation. We're happy to --

DR. HOUGHLAND: Okay.

SENIOR DEPUTY COMMISSIONER CECIL: -- think through that and see, you know, what we can do from our side.

DR. HOUGHLAND: Yeah.

MS. MOORE: With that information,

I'll second Barry's motion to adjourn.

CHAIRMAN MERRITT: Thank you. Thank you so much, Stephanie.

All right. Thank you so much, guys. I know today's meeting was bumpy. I appreciate it. I hope everyone has a great day.

SENIOR DEPUTY COMMISSIONER CECIL: Okay. Thanks, everyone. Take care.

(Meeting concluded at 11:54 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 21st day of September, 2023.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR