CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

January 28, 2021
10:00 A.M.
(All Participants Appeared via Zoom or Telephonically)

MEETING

APPEARANCES

Elizabeth Partin
CHAIR

Nina Eisner
Steven Compton
Susan Stewart
Jerry Roberts
Catherine Hanna
Ashima Gupta
Ann-Tyler Morgan
Garth Bobrowski
John Dadds
Peggy Roark
Sheila Currans
Teresa Aldridge
COUNCIL MEMBERS PRESENT

CAPITAL CITY COURT REPORTING
TERRI H. PELOSI, COURT REPORTER
900 CHESTNUT DRIVE
FRANKFORT, KENTUCKY 40601
(502) 223-1118

AGENDA

AGENDA
(Continued)

DR. PARTIN: We will call the meeting to order, and, Madam Secretary, call the roll, please.

(ROLL CALL)

MS. ALDRIDGE: That's the end of the roll call, Dr. Partin. We do have a quorum.

DR. PARTIN: Thank you very much. Okay. So, next up on the agenda is approval of minutes. Would somebody like to make a motion?

DR. COMPTON: Steve Compton. I so move.

MS. EISNER: And I'll second that motion.

DR. PARTIN: Thank you. Any discussion? All in favor, say aye. Anybody opposed? Thank you.

We're going to be a little bit flexible on the agenda and we are going to go ahead and go to the KHIE update.

MS. HUGHES: Andrew, I'll let you introduce yourself, please.

MR. BLEDSOE: Yes. Thank you. Good morning, everyone. My name is Andrew Bledsoe. I'm the Deputy Executive Director for the Office of Health Data and Analytics within the Cabinet for

Health and Family Services and work very closely with the Department for Medicaid on providing HIE services.

So, let me share my screen and we can jump into exactly what that is. If someone can let me know that you're able to see my screen, I'll jump in.

MS. HUGHES: We can see it.

MR. BLEDSOE: Great. So, What is an HIE? So, just really quickly, I'll talk from a high level. I was given fifteen minutes today to speak, so, I thank you for having me today and I'll try to keep really closely to my fifteen minutes, although I think I have eighteen slides. So, I'm going to talk really quickly.

What is an HIE? Health information exchange as the verb is really tied to electronic transmission of health-care-related data and this can be between any type of health care facility, hospitals, doctor offices, government agencies, anything. It's just moving health care information.

And the purpose of an HIE is to promote the appropriate and secure access and retrieval of a patient's health information to

improve the cost, quality, safety and speed of patient care.

Now, I hate reading from a slide but I wanted to read that exact statement because it is so important what we do and why I'm here today to tell you about our services.

So, who are we? I just love hearing people try to pronounce our acronym. I call it KHIE, and, so, the Kentucky Health Information Exchange. We are a very unique Health Information Exchange. We are housed inside of state government, inside the Cabinet for Health and Family Services.

Most HIE's around the nation are set up as typically an independent, for-profit or nonprofit organization providing services to health care, industry, government, but they aren't ingrained into the state's government the way that we are.

So, we are housed inside of the - the project that is KHIE, the service that is KHIE, is housed within the Cabinet in the Office of Health Data and Analytics and really provides such an incredible benefit to the health care community for Kentucky.

It allows us to very easily collaborate with all the agencies inside of the

Cabinet on many different initiatives. We'll actually talk through these a little bit in depth but we can work very collaboratively with Medicaid which is why I'm here today. We do a lot of work with Public Health to facilitate public health reporting, Behavioral Health, DCBS, Vital Statistics, a lot of opportunities so that we are more coordinated for the health care community and the services that we are able to provide.

So, what do we do? We talked about what an HIE's function is. This is kind of how we operate. This is a very high level and by no means is all inclusive with the names on here. These are just a few organizations that we work with for the over ten years of our existence; but what this is meant to depict is the bidirectional flow of information, both a push and a pull of information.

Now, the pushing of information is a couple of different things. It can mean that you are being a good steward of your patient's information. You want to do coordination of care with that patient and you want to make sure that their information is able to be provided to other providers who may be treating them.

So, you can be pushing clinical

information into the HIE so that it's discoverable and viewable by other health care agencies. It could also be that you're pushing public health data into the HIE. So, both ways, we're pushing information into the HIE.

Now, the pull of information is you're working with patients and you may not know all the information about them. Maybe they're a new patient. Maybe they're being transferred to your facility or maybe they just simply can't tell you what medicines they have been prescribed from some of their other health care providers.

So, the pulling of information is asking KHIE what information can you tell me about this patient and, then, you pull that information back into you.

So, rather than you having to go to all of these facilities to say give me information on Andrew Bledsoe. That's my patient. You ask KHIE one place and we do the work of going out to all of the entities to say give us all the information you have on Andrew Bledsoe, and, then, we can present that back to you in an easy-to-understand format.

So, I like to show this because

there really is two sides to what we do. We love the services that we're able to provide for organizations so that you can receive data from us; but in order for us to be robust in the amount of information that we can provide to you, we need organizations contributing data into the HIE as well.

I love this slide. I think it's as old as our organization is, but what this is depicting is the difference in claims' information and the clinical data that we as an HIE exchange.

Most people when I start communicating with them about what we do as a Health Information Exchange, they just automatically go to claims' information.

While we do have some claims' data, and it is just incredible what we've been able to do with claims' information over the year from a payment perspective, from quality programs within the HIE, we've received a lot of value from the claims' data, but KHIE, we exchange clinical information.

So, when you or a health care organization puts anything into an EHR system, that's what we capture. So, that could be vital information. That could be transcribed or dictated notes from a patient encounter, an Emergency

Department report, an operative report. Data that is stored inside of your EHR is what we collect and that's what we exchange.

So, you enter it into your EHR. We catch it on the backside and we send it to the facilities who would need or want to see that information, and it really gives us a much deeper breath of information that we are able to provide.

So, the claims' information is going to tell you that an encounter occurred, that a procedure was done, that something was prescribed. With the EHR information, we can tell you exactly what happened during that encounter, what was the vitals, what was the results of the lab tests that were ordered. So, I like to show this just to kind of explain the difference in what we are able to show.

Now, I will talk pretty quickly through this but I like to be somewhat specific in explaining the information that we do capture.

You'll see the first line here is ADT or patient demographics. ADT stands for admit/discharge/transfer. Now, this is one of the most vital pieces of information that we can collect and provide on patients.

This does really two things for us. One is it establishes a patient as a unique patient inside of our system. So, instead of there being Andrew Bledsoe or Andrew Colton Bledsoe and Adolph Bledsoe as three different patients inside of our HIE, we use these ADT's and the patient demographics that are contained within to consolidate all three of those into one unique individual.

So, this means when you are searching the HIE for patients, you're not having to look at multiple Andrew Bledsoes to see which one has the most updated information. You have the most recent and relevant Andrew Bledsoe all comprehensively in that one profile.

Additionally, as you're sending information, we attribute everything to the correct patient, and we have some powerful systems on the backside that help to manage this for us and we have 99.99% match rates with our Master Patient Index.

It also tells us where patients are seeking care. And, so, it can tell us that patients are being admitted or discharged to facilities and, then, it gives us demographic information about those patients and, then, some information about that encounter.

It is one of the most powerful pieces of information that we can collect and one that we seek to obtain when we are first working with an organization.

Moving down this list, we work with lab results. We have connections to reference labs, commercial labs across the State of Kentucky. We exchange lots of lab information - I'll show you some information on that - radiology reports. We have transcribed reports. We're also working on a project to exchange actual radiology images. Transcriber notes is often dictated, operative reports. CCD's is kind of like a summary of an encounter.

I like to think of this, if you go to the Emergency Department, for example, and you're walking out the door, they're going to print you a stack of papers that's going to tell you what was done during that encounter, what medicine was prescribed, what tests were ordered, what the results were, why you were presenting.

Similarly to how an Emergency Department is going to print that and hand it to you, they send us an electronic copy of that and that's what is listed as Summary of Care in our HIE. Now,

we receive that from all different types of organizations, not just Emergency Departments.

Medicaid claims, we do show any paid Medicaid or MCO claim inside of our system, as well as a lot of the Public Health data.

How much data do we exchange? I'm not going to talk through this, but I am going to point out that 95% of the hospitals in Kentucky are sending data into the HIE. So, we're very close to having a complete representation from the hospitals.

We have a significant amount of ambulatory facilities. We have some non-traditional contributors. All the community behavioral health centers are submitting data to the HIE. We have city, county and state correctional facilities, as well as the EMS. We do have just under 5,000 feeds submitting data into the HIE.

And a little bit about how much data comes in in a month. We receive an estimated sixteen million messages in just one month of data coming in to the HIE.

So, kind of between the amount of connections that we have and the amount of data coming in, you can see that we have a lot of data that makes it powerful for us to be able to provide

back to health care organizations.

And, so, this blue chunk here is ADT's that we talked about being the most vital and important piece of information. Then, we have lab test results. And, then, even though some of these slivers here look pretty small, radiology, 100,000. That's still 100,000 radiology reports that's available in HIE.

I'll give copies of this afterwards and you can dive a little deeper into that. So, that's the data that we exchange.

I want to talk about how do we make that data available. This is all of the ways that we make, all of that information that we just talked about available to health care organizations.

ePartnerViewer is a Web-based portal and anyone can have access to that who has HIPAA authority to view patient information. You log into the Kentucky Online Gateway and you access our ePartnerViewer tile and you query for individual patient information.

So, you would query Andrew Bledsoe and my date of birth, and we go out and we do that collection of all the information that we have and we provide that to you.

Platinum is we can take all of that information and actually send it directly into your EHR system. And, so, this is really true interoperability that's requiring very minimal workflow changes.

The downside to this is it can be costly from your EHR's perspective. We do not charge for any of our services right now because of federal funds made available to us, but EHR systems can charge for this connection. And us sending the data to your EHR means that they didn't have to collect that information and make it presentable in our system.

So, there are some mapping processes that have to be followed. So, that one can be a little bit costly, but, again, it's really where we're getting into true interoperability inside of current work flows.

Event Notifications is making our data proactively available to you. So, rather than you having to query for information, we can tell you through our Event Notification System when your patients that you have elected to track have had information available in the HIE, so, if they've been admitted to a hospital, they've been admitted or

discharged from a behavioral health facility. We have about twelve different types of event notifications. You just have to tell us which patients you want to track; and anytime that they have one of those events happen, we notify you that that has happened.

We can do that through a couple of different mechanisms that is designed to meet your current work flow as much as possible.

We have launched our CMS CoP Electronic Notifications. This is using our Event Notification System to meet your CMS Conditions of Participation for the ADT, the patient interoperability or patient access rule.

This goes into effect May 1st. We're doing a webinar on this February 5th. If you have more questions on that, I can point you to that webinar and we're going to talk really deeply around what your requirements are and, then, how you can use our solution to meet your requirements for that.

Direct Secure Messaging is an email system that you can send protective health information over.

Patient Alert Query is another proactive service. It's a simple question you build

electronically in your system. So, if you start an inpatient encounter, your system can be set up to say, hey, KHIE, what do you know about this patient and we're going to tell you back their COVID status, they've had a lab test, a COVID lab test result logged in our system. We're going to tell you if they have an XDRO positive lab. We're going to tell you if they are an OSA patient and if they have an NAS diagnosis logged in their history as well.

And, so, that's a simple query service but can tell you a lot of useful information.

Image Exchange I want to talk about in just a minute.

Interstate Exchange, we are collaborating with Indiana, Ohio, West Virginia, Tennessee to exchange information with them across borders. We do ADT exchanges and CCD exchanges with them.

We do have a lot of Social Determinants of Health data. I've got just a few more slides on that.

We also have KASPER data, again, pointing to that benefit of KHIE being inside the Cabinet and our ability to easily collaborate with other agencies. We talked about Medicaid

claims.

We also access federal data. We are working to get the VHA data. Actually - I'm sorry - we went live in December and can now access Veterans Health data, Department of Defense data, and we're working on a Social Security Administration use case where we can send on your behalf Social Security eligibility information on patients when we are asked for it. So, that's a new use case that we're working on for this year.

We facilitate Public Health reporting. So, instead of having to build a connection to each one of those specific registries, you build one connection to KHIE. You send it off. We've got one connection and we send it where it's supposed to go on your behalf.

DR. PARTIN: Andrew, can I interrupt for just a second before we move to a different slide?

MR. BLEDSOE: Sure.

DR. PARTIN: I had a couple of questions. One is, when we view the information that we request, would there be a way to print that, like, copy it and print it?

What we do at our practice to

avoid those extra costs with the EHR is that we have a separate server where we scan information into a patient's chart and that doesn't add to our cost, then, with the EHR.

MR. BLEDSOE: There's a couple of different ways that that can occur. You can print it or you can export it via direct secure message and, then, that way, it can go directly into your EHR system, but there's a couple of different ways that that can be handled, yes.

DR. PARTIN: If we don't want it to go into the EHR system, if we want to print it and then scan it, then, we can do that?

MR. BLEDSOE: Yes.

DR. PARTIN: And, then, how long does it take to receive the information once we make a request?

MR. BLEDSOE: Everything is realtime. You log into our system. You would query the patient you're working with and it takes about three or four seconds to collect the information and it's right there available to you.

DR. PARTIN: Okay. Thank you. Sorry to interrupt.

MR. BLEDSOE: No, absolutely.

I'm trying to go through this quickly, but, absolutely, if anybody hsa any questions, let me know.

We talked about Public Health reporting. Just a few things that we've done during the COVID pandemic. We've worked, as I mentioned, a lot with Public Health. We are facilitating COVID positive and negative lab tests.

So, anytime a commercial lab or a facility is doing lab tests for communicable diseases, they're required to tell Public Health they have done those and required to tell them the report. We can electronically capture and send that information to DPH.

We also do Electronic Case Reporting, a couple of different connections there. We connect with EHR or you can enter that into the ePartnerViewer. So, if you've done a COVID lab test and you have a positive, you have to send a case report and, then, now we're moving into the COVID vaccine.

So, we do connect to the Immunization Registry. So, if you are receiving the vaccine, you are accepting the responsibility to tell the Registry that you have administered the vaccine

within twenty-four hours of administering it to a patient. You can do that electronically through our system so that you can again ease your reporting burden there.

These are different ways that you can connect to us to submit COVID lab tests. We previously only had one; but during the pandemic, we've opened up four additional ways to be able to connect to us to make it easier for facilities.

We do capture that information in the HIE so that we can present it back to the clinicians and make it beneficial to you.

So, we display in our ePartnerViewer if you were looking at a patient, we show you all of their COVID lab tests they've had done and we can also send flags back to you through that query that they are currently in the window for having COVID or they have a historical COVID diagnosis, and there's also a VIN notification.

So, if you are tracking a patient and your patient tests positive for COVID, it will tell you that your patient has tested positive for COVID.

This is a glimpse into our ePartnerViewer and how we present clinical

information. The red bar here across the top says, you'll see Alert: COVID positive patient. That's how we are reading the COVID lab test results and presenting it to you in a useable manner.

We did a lot of work. In 2019, we launched a brand new technology platform. In 2020, we refined that platform and enhanced our services. In 2021, we are adding some additional services.

One is our Image Exchange. We just received approval from CMS last fall to launch into actually exchanging images. So, we will be connecting to hospital PACS systems and we will exchange from PACS to PACS.

So, if you are on a different PACS system than another hospital, we can send them to other facilities. We are also making them presentable in our ePartnerViewer. So, if you need to view a patient's image that they have had done in the past, you can log into the ePartnerViewer and see those images.

So, this is a brand new service. So, we're going to be working with hospitals to start building those connections so that the information will be available, but it will take

us a little bit of time to get the connections in place with the hospitals and build back repository images for you, but I'm very excited about this opportunity and what it can provide to the health care community in Kentucky - coordination of care.

We have a lot of Social Determinants of Health information actually. This is coming in through ICD-10 codes and LOINC Codes. So, we are working closely with the Kynect resources here in the Cabinet as well to make the Social Determinants of Health data understandable and usable.

So, when we receive that, we will display the Social Determinants of Health information in our system. We are also mapping it to the red, yellow and green status that Kynect Resources uses so that we are syncing up our system and their system and, then, we are feeding that into the Kynect Resources so that their community partners can have a better understanding of who may need access to services and can be able to send those patients to seek out those services.

We are also allowing users inside of our system to have single silent access to the Kynect Resources Engine. So, if you are working

with a patient and they have a Social Determinant of Health, you can right there on the spot connect them with resources.

This is how they show up on our patient summary page. And, then, if you click into it, a more detailed screen here shows you more information and, then, how they are ranked here with the red, yellow and green.

I know I went a little bit over. So, I apologize. Please check out our website, khie.ky.gov. Actually, if you click on that Get Started button, it will link you to our outreach coordinators and they can talk to you about how to access any of our services, how to connect to us to submit information or to receive information.

So, I really appreciate the ability to be here today and I apologize for going a few minutes over.

DR. PARTIN: Thank you. Can we have access to your slides?

MR. BLEDSOE: Yes. I will get them to Sharley and she can send them out. Is that appropriate?

MS. HUGHES: Yes, and we'll also put them on the website, on the MAC website for you

all to access anytime also.

MS. HUGHES: Thanks, Andrew.

DR. PARTIN: So, moving along on our agenda, we'll go back to A - what State Plan Amendments or SPAs to incorporate changes made under emergency orders have been submitted to CMS?

COMMISSIONER LEE: Good morning. So, currently, we're still working on telehealth information. As you know, there are some bills that are going through the Legislature in this Session also related to telehealth.

So, currently, the main thing that we are looking at are incorporating a lot of the telehealth flexibilities that were put in place during COVID, and right now we have not submitted any State Plan Amendments but we are definitely looking at telehealth services.

DR. PARTIN: Thank you. In line with that, Commissioner, I was wondering. In light of the bills that have been passed by the Legislature and the Governor's veto regarding his emergency orders, and, then, the likelihood that the Legislature will override those vetoes, telehealth flexibility is part of those emergency orders.

So, I was wondering if DMS has

any plans regarding that problem that's going to crop up as soon as the legislators veto the Governor's ability for those emergency orders.

COMMISSIONER LEE: I'm not sure exactly which issues may crop up, but our telehealth services, the flexibilities right now are granted under an 1135 Waiver. And we believe, based on communications, that President Biden is going to extend the public health emergency throughout all of 2021.

So, our telehealth services are approved through the federal 1135 Waiver that we submitted at the beginning. So, we should not expect any changes in the delivery of our telehealth services currently.

DR. PARTIN: Okay. And on that same topic, is that also covered with out-of-state providers providing care?

COMMISSIONER LEE: Our 1135 Waiver does cover several components. Anything that is a flexibility right now that's covered in our 1135 will continue until the end of the public health emergency.

DR. PARTIN: Okay. So, that would include out-of-state providers being able to

provide care in Kentucky?

COMMISSIONER LEE: Yes.

DR. PARTIN: Okay. Wonderful. Thank you. That was a big concern of mine. So, that puts my mind at ease a little bit. Thank you.

Did the amended regulation on copays pass the Joint Health and Welfare Committee?

COMMISSIONER LEE: Yes. We're happy to say that our regulations did pass the Health and Welfare Committee.

And if you're keeping tabs on the bills that are being put forth through this Session, there is a copay bill that has been proposed to eliminate Medicaid copayments.

So, just to remind everybody what our copayment regulation did was align with the statute that is in place that states that Medicaid shall collect nominal copayments for three specific services which is non-emergency use of ER, prescription drugs and non-emergency use of an ambulance.

So, what we did in our regulation is we amended our regulation to allow each of those services to be assessed a $1 copayment. And once an individual pays the $1, then, their copayment

amount for the year is met.

So, that regulation did pass. And also just as a reminder, under the public health emergency, all copayments have been waived which now are the $1 copayments for those three services and all of our Managed Care Organizations do not charge copayments going forward. They have opted not to include any of those $1 copayments going forward. So, there are no copayments for Managed Care members at this time.

DR. PARTIN: Excellent. Next would be the update on the 1115 Waiver for treating incarcerated people. Has that been submitted to CMS; and if so, was it approved?

COMMISSIONER LEE: That has been submitted. It has not been approved yet. They do have public comment periods. We are waiting to hear back from them but it has been submitted and we're hopeful that we will hear some positive news soon.

DR. PARTIN: Okay. So, should I put that on the agenda for next time and maybe we'll have some information on that?

COMMISSIONER LEE: Yes. And as I go through my updates, we have an Active Projects List and we'll definitely keep that on our Active

Projects List for an update as we continue going to the MAC meeting.

DR. PARTIN: Okay. Great. Next on the agenda is for reimbursement for more than one visit per day for Medicaid recipients. For instance, if a Medicaid recipient goes to their primary care provider and, then, goes to a specialist, for instance, a psychiatric provider, on the same day, my understanding now the way it's written is that only one of those providers can be reimbursed that day.

COMMISSIONER LEE: I believe that that is true. I think that there was something in the system, and I want to make sure that I clarify, too, that FQHC's and RHC's, federally-qualified health clinics and rural health centers, are reimbursed on a PPS rate. So, this would not be applicable to them.

Their reimbursement rates are such that if an individual sees two different providers in the clinic, then, they receive the one PPS rate back.

That has not changed, but I believe that we are working on a change order to ensure that individuals can see a primary care doc and a specialist in the same day.

DR. PARTIN: Okay. That's important, I think, for our patients transportation-wise especially from my perspective in a rural area because people try to group their appointments together because transportation is a problem.

And, so, they may not be seeing two different providers in the rural health clinic. They may be actually seeing two different providers in two different practices on the same day. So, are you looking to change that?

COMMISSIONER LEE: Yes, we are. It's my understanding we have a change order in our system to prevent those claims from denying when they're submitted on the same date of service.

DR. PARTIN: Do you have any idea when that's going to go into effect?

COMMISSIONER LEE: I do not but we'll keep it on our list for the updates for the next MAC.

DR. PARTIN: Okay. So, I'll put that back on the agenda.

Next is an amendment to the regulation for the rural health clinics, 907 KAR 1:082 which says that the documentation for the visit has to be completed on the day of the visit.

Any movement on that looking to make that at three days?

COMMISSIONER LEE: We are definitely looking at all of our regulations. We believe that it does make sense to have alignment when we can do that. So, we are looking at it. We haven't moved to open that regulation yet but we are looking at not only the rural health clinic reg but all of our regulations to ensure that there is consistency among our practices.

DR. PARTIN: Okay. Do you have any idea when that may be happening?

COMMISSIONER LEE: No, but we can keep it on the agenda for the next time.

DR. PARTIN: Okay. The next item is suggestions from the MAC on how to improve the problem with low birthweight babies.

I've done some research on that, and I really, really appreciate you, Commissioner, coming to us with this and having the opportunity to provide feedback and suggestions because I think this is an important issue for us in Kentucky.

So, if members will indulge me, I do have several suggestions and information. And

if anybody else has anything after I do, then, please speak up.

So, I've got a little bit here, so, I'm just going to read it. Just in preface, low birthweight is defined by less than five and a half pounds. In 2018, one in eleven babies in Kentucky were low birthweight. Kentucky did not meet the Healthy People 2020 objective of no more than 7.8% of live births to be low birthweight.

And in the most recent Kentucky data, it shows that 8.9% of all births in Kentucky are low birthweight, but, strikingly, 14% of those low birthweights are African-American babies. So, when you look at all births at 8.9% and, then, African-American babies at 14%, to me, that's pretty striking.

Smoking leads to low-birthweight infants. So, we need to focus on trying to get people to quit smoking.

And, then, I have some data on Certified Professional Midwives. And I think you mentioned that in a previous meeting about DMS looking at other states to see how many have licensed CPM's. And as of January 2018, which was the most recent data that I could find, thirteen states

Medicaid reimburses CPM's, six states mandate private insurance coverage and, then, thirty-two states license CPM's, and Kentucky is one of those states.

So, having said that, my suggestions are to extend Medicaid reimbursement to CPM's; support House Bill 92 and Senate Bill 76 to remove the certificate-of-need requirements for birthing centers.

Evidence shows that birthing centers improve paternal and child health, and I think this would be a big improvement in Kentucky for improving access to care for mothers and babies.

Increase efforts to help pregnant women quit smoking; decriminalize or non-mandatory reporting of marijuana-positive mothers. A possible positive test keeps women from seeking care in the first trimester. And, so, if at least it wasn't reportable, I think that would encourage women to seek care early in their pregnancy which is important.

Improved access to birth control which can help space pregnancies; support House Bill 27 which has been sponsored by Representative Scott which calls for implicit bias training in perinatal centers and gathering data on

mothers and infants; support House Bill 212 which is sponsored by Representative Heavrin which calls for demographic data on maternal child deaths; and support Senate Bill 78 which is sponsored by Senator Julie Racque Adams to remove barriers to practice for APRN's including Certified Nurse Midwives which will improve access to care.

This, coupled with birthing centers, would help to improve access to care because if that barrier is removed, then, more CNM's will be able to function in birthing centers and provide that access.

Perinatal care coordination through Health Departments. This would assist both urban poor and rural communities. Many times in rural communities, in my county, there is no OB care but all the counties have a Health Department. So, it would be helpful.

And I know Health Departments provided that in the past but I think that has gone away. So, that would be important, I think, for helping women to access prenatal care.

Group prenatal care. There was one multi-state study that was done with 1,047 participants and it showed significantly fewer

pre-term births in the group care group; and, then, DMS to connect with Kentucky Perinatal Quality Collaborative which is a group found within Kentucky government that's looking at improving perinatal care.

And, then, lastly, some of these suggestions were mine but I also consulted with two people from Frontier University - Victoria Burlsem who is a Nurse Midwife. She is faculty at Frontier Nursing University and president of ACNM. I can't remember what that acronym stands for, but, anyways, she's president of the Kentucky affiliate.

And, then, Dr. Kendra Faucett who is also a Nurse Midwife and she is the Course Coordinator at the Department of Midwifery and Women's Health and they have both offered to be a resource for you if you would like to contact them, and I can share their contact information with you.

And, then, I don't know if Sharley has shared with you the email that I sent her, if you saw the email that I sent last night with all the articles supporting the suggestions that I've made, but there's a lot of literature out there supporting all of those things that I suggested.

COMMISSIONER LEE: Sharley did

share the email with me and I did send that along to Dr. Theriot. She has been very involved in all topics related to maternal and child health. She will be specifically looking at all of these recommendations.

And I so appreciate, Dr. Partin, so appreciate the MAC taking this up and bringing these recommendations forward. I think this is the good work that we can do to improve the health of those we serve.

When we identify issues and concerns like this through not only information that we have in the state but from national reports showing our standing in some of these benchmarks, I think it's very important for us to look at these topics, these issues that are impacting the health of those that we serve and look at recommendations and work together to try to implement as many of those as we can.

And I definitely am so appreciative of these recommendations and helping us look at some of the things that are barriers to us improving these low-birthweight baby issues, and I think this is the very first of important conversations, that we need to maybe keep this on the

agenda as we go forward and have updates from Dr. Theriot and some of the Managed Care Organizations on these recommendations and what we're looking at and how many of these recommendations we may be able to get implemented in the short term versus long term.

And, then, I think we need to work also to gather some baseline data and maybe set some goals on what we would like to see in short-term improvements and long term.

But, again, I think this is exactly why the MAC is here is to help guide those policy changes and we so appreciate it, and we look forward to looking at all of these recommendations, and not only within the Department.

There are some recommendations I think that we will need to look at and get other departments and other stakeholders involved in; but, again, thank you so much and we do look forward to going through these recommendations.

DR. PARTIN: Thank you. Does anybody else on the MAC have any suggestions that you worked on since the last meeting regarding this topic?

Okay. Well, if you all think of anything, please bring it forward because I think

it is important to make these suggestions on this and any other issues that the Commissioner brings forward. Again, I'm just really happy that you're engaging us and I appreciate that opportunity. Thank you.

COMMISSIONER LEE: Thank you.

DR. PARTIN: Okay. So, next, Commissioner, you're still up.

COMMISSIONER LEE: If I can share my screen, I do have some updates. I think it's important always for the MAC to keep updated on current enrollment trends in the Department.

I think this report will give you some good information. It's broken out by region and also by Managed Care Organizations. This is our Medicaid enrollment as of January 25th, 2021.

We currently have 1.6 million individuals enrolled on the Department. These numbers are updated also and put on our website each month, but the numbers we're looking at here I get on a weekly basis. So, this came from our January 245th report.

The Region that says 00, that, I believe, is for individuals who we don't know exactly, maybe their region isn't specified or they

are actually out of state. They may have guardians that are out of state. So, the address listed is not within one of our regions.

Also, I'd like to point out that under the Aetna enrollment, as many of you know, January 1st, 2021, we moved individuals who are enrolled in the foster care program into SKY, the Serving Kentucky Youth.

So, in that Aetna total enrollment, 27,891 of those individuals are our SKY members.

So, some current projects, active projects that the Department is working on and we continue to work towards implementation of it is our PBM RFP, our fee-for-service PBM RFP. We just released that. It is out on the streets right now.

So, we will be procuring a new Pharmacy Benefit Manager for our fee-for-service population and that's the population that is in long-term care facilities and our waiver populations.

Our MCO Pharmacy Benefit Manager contract has been awarded. The company that was awarded the contract is Medimpact. However, that contract is under protest but we have received approval from Finance to continue work towards

implementing our Managed Care Single Pharmacy Benefit Manager while the contract is under protest.

I'm sure many of you who watched the Governor's press conference have seen information about our Hospital Reimbursement Improvement Program. This is a program that we worked collaboratively with the Kentucky Hospital Association, and this will actually be bringing more federal dollars into the State of Kentucky.

It will not impact Medicaid's overall budget because the hospitals are going to be putting money up for this program. This is very similar to a program that we have had in place for a while in which we reimburse university hospitals. We provide more funding for them through specific reimbursement methodologies.

We do have a summary page that we will be posting on our website and will be more than happy to do a more in-depth presentation on what the Hospital Reimbursement Improvement Program is and what that means for the State of Kentucky going forward.

We have also implemented our Single Preferred Drug List. As you will recall, each MCO had their own Preferred Drug List and the fee-

for-service also had a Preferred Drug List. So, there was legislation that mandated that we have one single list, so, that has been implemented. We think it's gone pretty smoothly for the most part.

There were a couple of medications that were not on our Preferred Drug List that fell outside, and I may have to have Dr. Joseph help me a little bit, but there were a few medications that fell outside of the Single Preferred Drug List that were used for I believe substance use disorder treatment that had a prior authorization on it and we talked with the Managed Care Organizations but we resolved that issue and, again, believe that everything is going pretty smoothly with the Single Preferred Drug List at this time.

As we mentioned earlier, the 1115 Waiver for incarcerated individuals is at CMS for review right now.

We currently have a lot of new occurrences related to our information technology. We used to have one system that contained all of the information, the claims, eligibility, that sort of thing.

So, we're moving to these modular components that will allow us to be more

flexible in our information technology needs as we go forward. Again, if you would like a more in-depth presentation on what that means for the Department and how it may even impact providers, we would be more than happy to give a more detailed presentation at an upcoming MAC meeting.

We have also our Electronic Visit Verification. We received confirmation from CMS that our system is in compliance with their requirements related to EVV.

We had a little bit of a scare at first. We thought that we may not be in compliance. And when we went back, took a look, we are now ready to go forth in phases.

So, currently, our Electronic Visit Verification is operational for all. There are six components that individuals or providers can input into our EVV system. That is what's required for CMS right now. So, we do meet that requirement.

Our claims and reimbursement piece for the EVV is going to be in a different phase. We were trying to do all of that together. So, that's why we thought we may have some issues meeting the criteria; but since reimbursement and claims was not required as part of this first wave of

EVV criteria, we are in compliance and will be. Again, this is something that we can do a more in-depth presentation at a future MAC if you are interested in that.

Our Home- and Community-Based and Model II Waiver renewals have been submitted to CMS for review. That's been recently. So, we are waiting for information on their review.

Appendix K is part of our Home- and Community-Based Waiver. It gives us flexibilities relating to waiver services. We are reviewing that and updating it to CMS for a renewal at this time.

We also have our Program of All-Inclusive Care for the Elderly or PACE. It's on target to have providers serving the public in October or November. The go-live on that is going to be January 1st of 2022. Again, I'm more than happy to do a more in-depth presentation on the PACE Program if you would like that.

Another bit of exciting news is our missed appointment tracking that we discussed at the last MAC meeting, that's going to be put in KYHealth.net and it will allow providers to go in and actually document if an individual missed an

appointment and why. We have a target go-live date of March 25th. So, we are looking for volunteers to kind of look at the screens the way they are now and tell us how easy it is to use and also volunteers for testing.

So, if any of you would like to volunteer to look at the screens that we have in KYHealth.net related to missed appointments, reach out to Sharley. She will keep a list of those providers that are interested and we will reach out with specific dates and times for testing.

So, just a little bit of an update about the public health emergency due to COVID. As we mentioned earlier, all indications are that the public health emergency is going to be extended through 2021. So, that's exciting news for the Department, for our providers and also for our members.

We have started looking into some of our claims. Now, this information is all for claims with a U071 diagnosis code.

So, just looking at the diagnosis, that one specific diagnosis code related to COVID, you can see in our fee-for-service population that in March when this first started, we

had about nineteen members who had a COVID diagnosis. Claims, we paid out $576,000 in claims and it equated to about a $30,000-per-member amount for those diagnosed with COVID.

As you can going forward, we have had more individuals diagnosed, but the costs per member are being reduced. I believe that's an indication that we are learning more about COVID and maybe how to treat it better.

The total number of unduplicated members in our fee-for-service population who have had a COVID diagnosis is 14,988, and the total claim amount that we have paid is a little over $86 million.

When we compare that to the Managed Care population, you can see early on, again, we had about seventeen members in March who were diagnosed with COVID. The cost to treat those patients was $16,000 per claim. Total number of members in the MCO arena that we're showing with a diagnosis of U071, 25,000, and the total claim amount is $32,800,000.

So, just thought that was some information you may want to look at to just kind of keep us updated on how we are doing with COVID in our

population.

So, that concludes my slide show.

DR. PARTIN: Commissioner, will these slides be available on the website?

COMMISSIONER LEE: Yes, they will.

DR. PARTIN: Thank you.

COMMISSIONER LEE: We will share the slides.

And, again, anything that I touched on at a level that you want us to present on at the next MAC, we'll be more than happy to pull a presentation together and give a little bit more detailed information about some of the activities that we're currently working on.

And as I talked about enrollment, I don't know that I mentioned that it appears that there is also going to be a special enrollment period on the Exchange.

So, President Biden, I think he and his team are looking at and have decided to open up a special enrollment during this public health emergency for individuals who may be losing health insurance. If they don't qualify for Medicaid, they

can do an application on the Exchange and can get enrolled that way for health care coverage.

So, we'll definitely be sending out additional information as we see what those dates will be.

DR. PARTIN: Okay. Is that a for-sure thing that's going to happen? You just don't know the dates?

COMMISSIONER LEE: I received an email about it today with a Fact Sheet. I haven't been able to fully digest that yet, but we do believe that there will be open enrollment on the Exchange. So, as soon as we get those dates, we will be announcing those.

I will be glad to answer any questions if you have any. Any questions? I know that's a lot of information, a lot of things that we are doing here and some of those projects are definitely very important.

And if you would like more in-depth presentations on them, again, we would be more than happy to bring those forth and give you more information specifically related to how it impacts our providers.

DR. PARTIN: Appreciate that. I

made some notes because there are several things that you mentioned that I think would be helpful for us to have more information on. Any other questions?

MS. ROARK: Yes. This is Peggy Roark. I have a question for Medicaid recipients. When should you get the COVID shot because I have asthma and somebody said maybe you shouldn't take the COVID shot? So, who would I address this to?

COMMISSIONER LEE: Our Department for Public Health is organizing and is taking lead on all of the vaccine-related information. And I believe that they have a Frequently Asked Questions related to the COVID vaccine, and I can get that out to Sharley and she can send it to all the MAC members and that should have some answers on there for you, Ms. Roark.

MS. ROARK: I appreciate that.

DR. PARTIN: Peggy, I would also say that you should speak with your health care provider. I think people with asthma, I think it's being recommended that when it's their turn to take the vaccine, that they take it, but your health care provider would probably be the best person to answer that question specifically for you.

MS. ROARK: Okay. Thank you. I

will reach out to them. Thank you all for that.

DR. PARTIN: Any other questions? Thank you, Commissioner.

MS. HUGHES: Beth, we do have one more update. Kate Hackett has a short presentation on the provider enrollment system. We get a lot of questions on that. So, we wanted to let you all give us an opportunity to do that, if you don't mind.

DR. PARTIN: Sure.

MS. HUGHES: Thank you. Kate.

MS. HACKETT: This is Kate. Can you see my screen?

MS. HUGHES: We sure can.

MS. HACKETT: Okay. Everybody, thank you so much for inviting me to your meeting. I know your time is precious, but Sharley is right. We do get quite a few inquiries about the Kentucky Medicaid Partner Portal Application. So, it's exciting for me to be able to share this.

So, in talking with Sharley, it seems the best thing to do for this group right now is to help you to understand a little bit about Kentucky Medicaid Partner Portal Application; and if it's okay, I'm just going to call it Partner Portal

from here, and, then, the updates that providers can make using Partner Portal, and, then, where to find resources. I feel like that might be the best way to approach this.

It's not a live demonstration. These are slides that we crafted to help with the discussion. So, I'm going to go ahead and move forward, then.

So, as you know, as a result of KRS 205.532, every provider is required to use Partner Portal or an electronic means to make application. And, so, Partner Portal was developed in order for that to happen and it is the accepted system at this time.

So, from here, I'm going to jump right into the system on what can be updated and how it might happen, starting with how it might happen.

So, every provider can have a log-in and a dashboard for Partner Portal. Many providers what we learned have credentialing agents that have that function to help maintain that. And, so, just keep those two pieces in mind as we move forward.

So, Partner Portal is organized

with application tabs that is pertinent only for new enrollment and change of ownership, those who need a Medicaid ID, and, then, what we call a maintenance tab, providers that need to just update an address, update a license or they need to be reinstated or they've let their license lapse for a period of time and, so, they need to reapply. So, that's the maintenance tab.

And, so, those are the two big pieces that kind of help providers, once they come in, to navigate which way they want to go.

So, in maintenance, I've already got a Medicaid ID. I just need to get it reinstated or I need to reapply to get my Medicaid ID reactivated.

When you go into Partner Portal, everybody has this dashboard. And whenever you're updating anything, you'll see your dashboard button which will take you right back out here.

You can start an application here. You would perform maintenance by clicking this button, this Maintenance button.

And, then, there's electronic correspondence or notifications that we do. So, you would click on the Correspondence tab. And, then,

for those of you or those providers that have credentialing agents that work on your behalf, they will show an Administration tab and you would click on the Administration. So, by clicking on any of these, it will help you to move forward.

In a maintenance function, what you're going to do is you're coming to come down and select - you can come down and select Maintenance Status and that will help you to understand anything that you might have in progress or get started with a maintenance to update your provider file.

So, because we want to help you to understand how to update and what can be updated but how to update, we're going to move into I selected the maintenance. And over here on this side, you see - I selected maintenance - it's going to ask me for my Medicaid ID.

So, that will be entered in here. You will hit Search, and, then, the system is going to go looking for it and, then, it will populate the information, the effective date and other information that's available around that Medicaid ID into this grid that you see that's embedded here.

So, then, you tell the system,

I want to do a maintenance. I need to re-validate. I want to voluntarily terminate or along those lines. So, you tell Partner Portal what you want to do by clicking that button and it takes you into performing that maintenance.

So, every panel is organized with a left-hand navigation. So, you'll see that down here, down this side. It's bigger here so that you can see it, but this is what it looks like when you first open it up and go into maintenance.

So, just a few pointers here. Where you see the pencil, that means that's where you are. That's the panel that you can make an edit to, that you're ready to do business on.

Where you might see a circle with a slash like here in tax, NPI, taxonomy, those are fields or panels that are open to you to make a change on. That's because it's pertinent to you and your provider type.

For this example that I'm providing, it's an individual provider. So, I'm not a group. I'm not an entity. I'm an individual.

So, you will see that there's circles with slashes like bed data, locum tenens or teaching facility. For an individual provider, that's

not pertinent. So, we're not even going to let you get into that in Partner Portal.

So, as you can tell how it's been built is that you have access to everything that you need access to and you don't have to worry about those things. It's never going to be a part of your application to go in and tell us you don't have good data, you aren't a teaching facility because you're an individual.

So, that's kind of how this navigation is built so that you get to exactly what you want to get to. So, on the Basic Information screen, it will show everything that is relative to you, to me as the provider.

So, I'm going to scroll down. Did that scroll, Sharley? Yes. Okay. So, in here, this is an example of a panel of what you would see before you would make any kind of a data entry.

So, what you have here is we have bullet points on every panel that's pertinent to this panel and we have Help buttons up here so that when you click on them, they're expanded help information.

So, this is one of the Disclosure of Ownership questions and somebody would

select, if it's an individual and they're not going to be filing bankruptcy, they would just select N/A and, then, click Save and Next.

So, that's an example of how the panels are set up, every panel with Help and blue bullets that are pertinent to that panel and, then, information in that panel just about that piece.

So, we'll move forward on this one. NPI's are a big piece that gets updated. And as you can see in this grid, again, we have the blue Help bullets. We have the eye for the expanded Help, and then, the question mark which also has additional Help pieces, and it's more pertinent to other resources.

So, the eye will be about the panel. The question will be about here's some phone numbers to call, like our Contact Center if you have any additional questions.

So, with every panel, what's the beauty of Partner Portal is every panel is essentially set up so that you add information in the exact same format no matter what information you are trying to update.

In this case, we're going to use NPI as an example. So, I have an NPI listed and

it is my primary, and this action cell here means that I can either edit it or I can discard it. We highly recommend not discarding anything.

So, any button would then bring up this information so that we can say it is no longer primary. So, we might select the Yes button to uncheck it; but in all cases, I have to select Add to Grid.

And when I add to grid - I'm sorry - I went the wrong way. When I add to grid, it puts the information back in here. I don't have a slide that actually showed the No. I recognized that this morning in practicing that my No slide was missing.

So, I can get that inserted so that you would see the actual results once I had unchecked Yes, hit Add to Grid and it would populate as No.

If I make a mistake on this grid, before I select Save and Next, I can discard what I've done and then start over. And, so, I would hit Discard and, then, I would go back here and, then, select Edit again; but in all cases, when you're finished making your update, no matter what your update is, we would select Save and Next.

License is another huge task for providers to keep current with Kentucky Medicaid. So, in the electronic world, we no longer accept the paper licenses coming in. Everything can be done right here in your portal.

In this example, what I'm showing you is that this license is expired on 12/30/2020. So, in this case, I, as a provider, or the credentialing agent, I would need to add - I'm sorry - I would need to edit this information.

And, then, once I moved to edit the information, it brings up the grid here. It brings it up for fields to be edited right down below.

So, here is where I would edit the license expiration date and I would tell DMS my new expiration date is 12/31/2022. And, again, in every case, I must hit Add to Grid in order for it to get captured. So, when I hit Add to Grid, it captures it right here. Again, then, I move to Save and Next.

I know I talk fast. So, feel free to slow me down if that's what you need to do.

So, the other piece to this, then, just to kind of keep us into the same frame of

mind is in both updates that I've showed you, I've done it the exact same way. I've selected Add or Edit and I added the information once it's populated at the lower piece of the panel and, then, I added to the grid and, then, I've selected this Save and Next.

The next thing I want to talk about because I think this is really important to you all are provider types that we are updating using batch processes, and I think this is especially pertinent to you all.

So, this is a list of provider types where we have a feed from the licensing board so that we can do primary source verification automatically and update the licenses of these providers without the provider having to go into Partner Portal and update their license.

The exception to this is if I, as a provider, I don't renew my license within two weeks of the expiration. When should I go in and I'm within that two weeks of expiration - I'm sorry. Let me start that sentence over.

Should I have a license that's expiring within two weeks, I need to make the update within Partner Portal and I will need to upload the license. However, if I do it on the other side of

that two weeks, then, Partner Portal gets that feed from the licensing board that does the updates for providers automatically. And, so, nothing is needed by the provider to keep this current with us.

To me, this is the biggest efficiencies that we have, and that's just speaking from the Provider Enrollment perspective, from the reviewer perspective.

From the provider perspective, for you all, having to keep track of license expirations and doing it with your licensing board and, then, getting it submitted to us in a timely fashion that we got it updated in a timely fashion, for you all to meet, it's even a bigger efficiency.

So, we're looking forward to continuing to work with other licensing boards and getting these batch processes where we can get them automated.

And I just want to do a couple of more examples of updates, again, to reinforce the process. So, this is where we want to lead to a group. Again, the panel - this is 5.0 - the panel is set up exactly like every other panel where I have the bullet points, I have the Help at the top. And in this one, when I want to do a group link, I have

to have the group Medicaid ID and, then, I would click Search.

Upon clicking Search after entering it, it populates this lower-half of the screen with the Medicaid ID and the FEIN and it gives me the group linkage date of the day I enter it, but I can edit that but it gets reviewed and, then, I can verify that that's truly the group by clicking Verify.

Then, it pulls everything down and it shows the group's FEIN and the name of the group. And if that's the group that I intended to connect to get linked to, I would select Add to Grid.

This, too, is a true efficiency. Rather than completing the paper pieces and making sure that other boxes or blocks were completed, just by knowing the group Medicaid ID, an individual can quickly get linked and verify that it is the group that they were intending to right away.

So, this is a realtime pull. It brings that information forward for everybody right away. And, again, as I said, don't forget to hit Add to Grid.

And this is what, once I select Add to Grid, it shows me exactly who I'm linked to

with their Medicaid ID, their FEIN and the effective date. If I ever want to end date this, it would be using the Edit button and, in this screen, I would end date it but that's just as an example. And please don't forget to in every case select Save and Next.

EFT is another common update that is made by providers. I want to share this one specifically because I want you to understand that we have a realtime validation on the bank routing numbers.

So, in this case, we enter a false routing number; and as you can see, it provided an alert to me that the bank isn't found. So, this to me is another efficiency to keep us from fat-fingering a couple of numbers or even a number and not knowing it until after DMS had reviewed it in the paper world.

You see this right away before you even submit it to us so that you can say, oh, man, I ended it with 122 and it should have been 123 or whatever the case may be, and it gives you the bank details and allows you to review it to make sure that you've entered everything correctly, the account number and, then, re-verifying the account number by

retyping it and, then, you select Save and Next.

And this is what it would look like, then. Once you click Save and Next, it just gets populated to a grid.

Not every update requires a document upload but some updates will require a document upload.

An example is, using this screen, if you are within that two-week period and you didn't get your license updated in time and you were part of the provider type set and do have the batch process to update, I would have to go in and update the license and, then, it would trigger that I need to upload the paper license as well. And, so, this is the screen that tells us the document type and that it's required.

Here, once I select - I had to make sure I was good. So, once I select I want to edit this, I want to edit the license, when I click here, it brings me to this screen which really populates just below it.

The example here - I should have started with the voided check but I said the license - through a drop-down, it automatically tells me what documents need to be uploaded. It lets me go

in and browse and get that document and, then, I can name that document whatever I want.

So, let's go back to here. So, in this case, if I made an EFT change, I would go into that Pin or make the change that I was going to do paper checks and, then, it's going to tell me that a document was required.

In this case, then, it takes me to this screen. Voided check or bank letter is automatically populated in this drop-down. I browse to go find, because I've scanned a voided check and saved it, I browse and go get it. I name it what I want to name it and, then, I add to grid.

And, then, once I add to grid, it gives me this information. It tells me that Joe Doe updated this on January 16th, 2019 and we're good to go.

So, everything once you upload tells us the user that did it and the date that it was completed. And, again, above all else, don't forget to select Save and Next.

In the case that you have a - let's say you're a provider and you have an additional document that you want to share with DMS and Provider Enrollment. You could be a provider

that, I don't know, some of the additional documents we get sometimes are liability or specialty or along those lines. You can select Add and it will populate this screen for you to add an additional document of your choosing.

So, you have the choice to add something that may not be required. Sometimes providers have an extra certification and it really doesn't fit with Provider Enrollment but the provider wants us to know they have it and that is all good and well.

So, it won't come up as a required document but you are welcome to upload it as an optional document to let us know that you had that additional certification. Maybe it's something that's relevant to the MCO and you feel like DMS needs to know as well. So, that's the document uploads.

So, my thinking based on the data that we've seen of the users of Partner Portal is that many providers have credentialing agents that do the work on their behalf. And as such, we have a function for a credentialing agent to operate as an authorized delegate and to submit applications on behalf of the provider without the provider having to

be involved.

So, let me review that really quickly. So, once I've Saved and Next here, I end my review. So, the review says you have a chance to go back and look at everything that you did on this update and it will start me with the basic information, but it shows it to me like - I'm sorry. I'm going to go here.

These are expandable arrows and it shows me starting at basic information but I can select from all of the panels by going to these arrows. So, if I updated a license and I might just want to go to the license. I don't want to look at anything else. If I did a group linkage, I might go just right down here to 5.0 and select that and look at what I did; but, regardless, at this point, you must select Save and Next to keep moving forward.

So, at this point, you are either the provider, the credentialing agent working on behalf of a provider and involving the provider, or what we have seen a tremendous amount of is a credentialing agent completing all the actions on behalf of a provider. And in that case, we call them an authorized delegate.

We have a screen that allows

you to pull the authorized delegate form. Many of you all already have this and the authorized delegate form is good for five years or until the revalidation date. So, if your revalidation date is less than five years out of the signature, then, we're going to ask you to do a different one and that's all part of the instructions that we have.

You could click here and download if that's what you needed but many of you already have it. So, you just click here at the authorized delegate and you sign and submit.

You go through the Terms and Agreement just like you would have in the paper world and you select I Agree. Again, go to Save and Next and, then, you're at the e-sign and submit where you enter to electronic signature. It automatically populates that this was a physician individual and when it occurred and, then, e-sign and submit.

It gives you a Results' screen that tells you what your application number was and what the provider type was. So, then, you could either print it if you want to store it or you can return to your dashboard.

So, those are the big pieces that I wanted to share about using Partner Portal to

update your provider file with us. Again, we try to ensure that we use the same methodology on every panel so folks aren't scrambling about, okay, this is a different panel. Do I do this differently?

You're going to do the same edit on the next panel that you did on the previous panel. It's just going to be pertinent to that panel and it works like that throughout. And, so, we're hoping that that is not just an efficiency but that is intuitive for folks.

The next pieces have everything to do with resources and support, whereas, with any new system, we know that there are glitches. We know that there are questions and we are happy to help with those pieces.

So, we support two Contact Centers. One is around technical pieces. Let's say your credentialing agent needs to get connected to your Medicaid provider number. They would do that through the technical support.

Everybody has to go through remote identity proofing or identity proofing I think is the better word in order to even create an account and clog to get to Partner Portal.

Let's say you had a problem.

Sometimes people have a problem with identity proofing and that's okay. So, that's where you would call the Technical Support number for assistance and they can provide realtime assistance. They can't see your screen but they can recreate what you're doing and understand what to do.

The next Contact Center that we support is Provider Enrollment. That's where policy or programs, application status, and they also walk through a lot of the application process. So, if somebody is stuck on a particular panel and they're dealing with this standard or that data, I'm confused about what date you really want me to put on here.

And, so, we are happy to answer those kinds of questions. We want you to call and resolve it as quickly as possible so you can continue to move forward on your application process.

We have a plethora of resources online. So, we have the Help Content on each of the panels, but, then, on our website, we have all the provider type summaries with their descriptions but we also have other pertinent information within the provider type summaries. When you click, it brings up a whole page of other information that is pertinent to that provider type.

And, then, on the website, we also have really good information on using Medicaid Partner Portal Application. We have your first button to click in and get entered, some of the help information that I shared with you today, and, then, additional job aids. And job aids are panel-specific and you'll understand what exactly is being asked there.

People are different. Some people need to call us to walk through it. Some people like to do it on their own and they're going to read anything and everything that's out there online. So, we like both and we're getting really good feedback when you all do that. We have training videos and other knowledge-based articles as well that are available.

So, this is how it looks here but this is what the website actually would look like. On the left-hand side is where you would see any kind of new announcements and those kinds of pieces; but on the right-hand side, it's some pertinent information to Provider Enrollment, Partner Portal, training, etcetera.

And, then, this is the top part of the page and this is the bottom part of the page.

So, you have to scroll down to find the rest of the training information.

So, Sharley, that's the presentation. I know I talked fast and I hope you all were breathing for me. I'd be happy to take questions or I'd be happy just to give this back to you.

MS. HUGHES: Thanks, Kate, for doing that. Beth, I'll turn it back over to you now.

DR. PARTIN: Okay. Thank you. If we could just share the slides, I think that will be helpful to everybody so we can refer back to it when we need that information. Thank you.

I have a question back to the Commissioner as I was thinking about your response to my question regarding the telehealth and the out-of-state providers.

When you responded to me on that about the federal emergency order in place, does that just apply to Medicaid or is that across the state?

COMMISSIONER LEE: That applies to Medicaid. The 1135 Waiver gives us authority to waive certain provisions. So, that applies strictly to Medicaid. I believe at the federal level,

Medicare also has some flexibilities in place. So, if there's a specific area you'd like me to look into, I could do that.

DR. PARTIN: Okay. So, it would cover Medicaid and Medicare but not any other.

DR. PARTIN: Our flexibilities apply to the Medicaid Program including the Managed Care Organizations who operate the Medicaid managed care for us. So, the flexibilities that I am referring to is strictly for Medicaid.

DR. PARTIN: Okay. Great. Thanks a lot. Okay.

Moving on, then, to our TAC reports, and we have covered a lot of material today. So, we still have a couple of items on the agenda after the TAC reports.

So, I would ask for those giving the TAC report, if you have information and don't have recommendations, just give us maybe a one- or two-minute update of what the TAC is doing, and if you have recommendations, just give us the recommendations so that we can get through the meeting on time. Thank you.

And first up is Behavioral Health.

DR. SCHUSTER: Thank you, Beth. I'm Dr. Sheila Schuster. I'm a licensed psychologist and Chair of the BH TAC and we met on January 6th with a quorum, all six MCOs and we had representatives from DMS including Dr. Jessin Joseph from the Pharmacy Department.

We do not have recommendations, so, I'm going to skip that, but I have a very important issue to bring forth and it came up actually after our TAC meeting on January 6th.

We had had Dr. Joseph join us both in November and in January, and, quite frankly, we were thrilled with what we were hearing from him about the new Medicaid Formulary.

We were told that behavioral health drugs would be on the PDL and would not be requiring prior authorizations; that people with behavioral health issues, antipsychotic medications would be in a protected class and would not have their medications changed; that there would be no failed first recommendations; that people would not be switched to other medications to try; that the injectables would be on the PDL and, therefore, there would be no PA's and everything would be great.

And that's what the Commissioner reported just a few minutes ago, but I'm sorry to report, Commissioner, that that's not the case on the ground.

I have spent the last two-plus weeks communicating with Dr. Joseph and with Stephanie Bates. It started first as a trickle and then as a flood of complaints all over the state from the CMHC's, as well as from BHSO's, as well as from privately-practicing psychiatry and we're finding that there are tons of problems.

I was communicating directly with Dr. Joseph and, then, he asked me to start forwarding what's essentially protected health information and I said I needed to get out of the middle of that and have all of the providers, prescribers communicate directly with Dr. Joseph.

So, I am frustrated. As you all know, we've had a BH TAC for the last six or seven years and our number one issue is access to medications for our people, particularly with severe mental illness.

We know what happens when they go in to a pharmacy and they can't get their medication. That fits the messages in their heads

and they walk out and very often don't walk back to the pharmacy to ever get their medications. And when our people don't get their medications, bad things happen. They end up under a bridge. They end up homeless. They end up back in the hospital. They end up in jail.

So, I am beyond frustrated at this point because I think we were very proactive. Dr. Joseph shared with me a directive or explanation actually that was dated November 4th and he shared it with me earlier this week. None of our providers had ever seen it.

I don't think this is an MCO problem. I mean, obviously, the MCOs are having to carry out the Formulary and they also were not prepared, but this is a systemic problem and it really needs to be solved.

So, I will stop at that point, but I just cannot emphasize enough how problematic this has been. And it's not just behavioral health drugs. We're hearing from people that they can't get insulin pumps for their grandchildren.

We're also being told that generic drugs are not being preferred, that people should go back to brand names. And that may be

because of the drug rebates that Medicaid gets, but it's so counterintuitive to what we've been doing because I think we have a great track record on using generics.

So, I just feel like there's been a total breakdown in communication even when we were trying to be proactive on behalf of our behavioral health Medicaid recipients. So, I will stop at that point.

MS. BATES: Sheila, this is Stephanie. I wanted to say a couple of things and, then, let Dr. Joseph speak. We'll tell everyone that I've also asked our MCO partners to be available on this meeting to answer any questions based on what Jessin says.

But we have heard loud and clear the issues that have come in, and I believe some of it - you hit the nail on the head that the generics that aren't necessarily on the Preferred Drug List have been part of the issue and, then, I think there were some issues with diagnosis codes.

And, so, Jessin, if you will kind of describe what we heard up to this point for the benefit of the group and, then, we can fall back on the MCOs to kind of talk about all the corrections

that they have put in place.

DR. JOSEPH: Sure. So, the Preferred Drug List is in its entirety a subset of all drugs that Medicaid is required to cover by law both from a covered outpatient drug status and also what CMS mandates the state to cover.

So, again, the Preferred Drug List is only going to be a set number of drugs. So, if you go on the website and you look at the products that we cover, there are products that we cover. It will pay at the pharmacy and it will not be listed on the PDL.

And that's because the way that the system is set up, we don't see a reason for us to put any edits on the drug. The drug class doesn't really need any more monitoring than what's already out there, and usually you see these drugs as your preferred products, no PA's. They come through fine. They did process fine. I'm sorry.

What we realized with the single PDL is essentially the list that we provided to the Managed Care Organizations did not include these other products that Medicaid fee-for-service covers.

When this occurred, the Managed

Care Organizations were instructed that they can place their own clinical criteria coverage on products that we at Medicaid are not providing any additional on. So, again, the PDL is where our focus has been.

What eventually ended up happening is those products that were not listed on the Preferred Drug List became non-preferred on the Managed Care end and those were your typical products that you would not normally have a PA on or any really edit on, and some of them may. You know, I should be careful about what - if I group everything together.

Some products do require a PA but most of these products, you're talking your over-the-counter prescriptions, things like Clonidine, and I would probably say Hydroxyzine is another good example that we were seeing coming across.

What we've instructed the MCOs to do at this time is to make sure that they are being clinically appropriate when they're evaluating these products. Again, we don't see any reason why a PA would be necessary on certain products and they have to have that rationale as to why they're putting a prior authorization there.

Again, the instruction for us and really from Senate Bill 50 is the Single Preferred Drug List.

We have within the contracts of the Managed Care Organizations that they are responsible for all covered outpatient drugs, and we will utilize the Single Preferred Drug List to ensure that the MCOs are aligning on drugs and classes and drug classes on that list. So, that, I think, is the initial concern.

The second concern that was mentioned - both are priority concerns - the second concern is around behavioral health medications and how they are processed.

So, the clinical criteria on the Preferred Drug List has the only criteria on those products to be just the diagnosis code. So, beyond the diagnosis code, we are not looking for clinical notes. We are not looking for laboratory values. It is simply the diagnosis code.

So, how we've set that up in the Medicaid fee-for-service space is we have an automatic Smart PA's is what we usually call it. Essentially, if the medical claims have shown that this patient has had a diagnosis for the preferred

agent, then, the claim will pay - no issues at all. It's all done on the back end. So, really, the providers would not need to be involved. As long as they have diagnosed their patient with the specific ICD-10 code, the claim would pay.

And we also have mobilized this for the pharmacies. If the diagnosis code is on the written claim, the pharmacy can put in the override to let that claim pay as well.

Again, when it came to how the MCOs implemented this, they looked at this. Again, they saw the clinical criteria piece on there and they operationalized this with a full prior authorization. And, so, this is where the provider volume has suddenly drastically increased.

We have instructed MCOs to move this to a Smart PA edit at this time. And, so, we should be seeing claims pay. I think the last MCO should get this ready by the end of this month.

If you are still running through issues, this is where the ask is to make sure that I and my team receive this information so we can triage with the MCOs as quickly as possible.

It's not the situation we want to be in. Again, the second we were made aware of

it, we called the meetings. I guess we did a root cause, identified where the issue is and we've tried to communicate as much as we can to the MCOs about what needs to get done.

I apologize that this has happened. Again, this is never the intent. We do want to be mindful about everybody's time.

So, I do want to make sure that that's clear, that we are working on a solution and it should be set up as soon as possible and we're really hoping for the end of the month.

The final thing I did want to point out is there will be certain products or certain products were sent out within a protected drug class. And Sheila is referring to products - and the notice that we sent to pharmacies regarding brands over generics, protected drug classes where patients would not need to be altered, again, this information is set up with the MCOs prior to the go-live date.

So, our instructions to them is we have these products. If the patient is stable on this product, then, we want to continue covering this product whether or not it is non-preferred.

The only exception where that

comes into play is if the member is going from a generic to now a brand over generic product where the brand product is the preferred agent on the Single PDL.

The PDL that we use has always been the same. It's the same fee-for-service PDL that we've used since I think 2012 is when we really started utilizing it in Kentucky Medicaid.

And, again, we add classes to it. We review these products every quarter with our P&T Committee. And the recommendations from a preferred status and a brand status comes from our analysis of the rebates but also from the P&T Committee's recommendations.

So, these dollars, I understand it is counterintuitive, but the back-end of this is for a cost savings to the State, and that's really where the brand over generic comes into play. Again, we account for all of this when we're setting up the rates with the MCOs.

And we're very mindful of switches from moving patients who were on the brand to the generic because of the fact that we know that pharmacies in this state already have stocked brand products and we don't necessarily want to make a

switch on day of without a transition period.

So, I did want to note all these things. Again, we hear your concerns. I apologize for the confusion and we are working to get this fixed as soon as we can.

DR. SCHUSTER: I appreciate that. It's so frustrating to me, Dr. Joseph, that you, our people in the Pharmacy Department and Medicaid did not anticipate that there would be these glitches.

I mean, it's unbelievable to me. We have comp care centers that are doing more PA's in the first two weeks of 2021 than they did in months in 2020. I mean, it's mind-blowing to me that there was no anticipation, I guess, on your part or on the part of somebody about the differences for the MCOs and for the prescribers and the lack of heads-up to the prescribers.

That's the function of the BH TAC and we had you at two meetings and didn't hear anything about this.

DR. JOSEPH: I can only do - I mean, again, from my position, I can only tell the MCOs what they're required to cover and what they aren't required to cover. I think I felt the

instructions to the MCOs regarding ensuring coverage of covered outpatient drugs was clear. I did not feel that we did not make that clear. Again, we had multiple meetings with all the Managed Care Organizations.

Again, I apologize. It was not meant to necessarily sidestep in any way.

DR. SCHUSTER: No. I'm not accusing you of sidestepping. What about the communication to the prescribers?

COMMISSIONER LEE: Dr. Schuster, thank you for bringing these comments and your frustrations to us.

I completely understand and again apologize for any miscommunication. I think that now that we're aware of these issues, our focus is going to be to correct, to make sure that our members do receive all the medications that they need in a timely fashion.

I think that this illustrates sometimes when we make these changes some of the small details that can be overlooked that actually end up causing some major issues for our members.

But, again, I hear you. I understand your frustration. Early on, I was made

aware of a couple of medications that were requiring a PA related to substance use disorder. I thought we had corrected that quickly. The insulin pump is a little bit new to me.

So, let's take this back. I'd like for me and you to take this offline and have a conversation and, again, we're here to assist and help identify what went wrong in this one to prevent it from happening in the future.

DR. SCHUSTER: Thank you. I would appreciate, then, followup information because the BH TAC is there to try to have this not happen. So, I appreciate that. Thank you.

COMMISSIONER LEE: Thank you, Dr. Schuster.

DR. PARTIN: Any questions for Dr. Schuster? Moving along, then, Children's Health.

MS. HUGHES: They did not meet, Beth.

DR. PARTIN: Consumer Rights and Clients Needs.

MS. BEAUREGARD: Thank you, Dr. Partin. I'm Emily Beauregard. I'm the Director of Kentucky Voices for Health and the Chair of the Consumer TAC.

We did convene two special meetings since we last reported to the MAC. That was on October 20th and December 15th. Both meetings we had a quorum, and I will share the recommendations that we made at those meetings.

Before I do, I know in the interest of time, we need to be brief, but something that is time-sensitive and I think related to what Dr. Schuster just shared, there have been so many changes recently with Medicaid, many of them good changes or will be good whenever some of these glitches are worked out, but, nevertheless, many changes that have happened between open enrollment and, then, the beginning of the year.

And I think that for both consumers and providers, it would be good to have just maybe a communication from DMS about these changes all in one place that we can be sharing so that all the same information is getting out to consumers and providers.

Some of those changes include new MCOs; the fact that open enrollment is basically still ongoing, that people can choose a different MCO between now and March 15th; changes in copays.

Something related to pharmacy

that we're still concerned about is that while we are thrilled the MCOs aren't charging copays and that there are fewer copays generally, that these nominal copays are $1, they're for only three services for fee-for-service; but we know that with pharmacy in particular, when copays were mandatory, people were being turned away even when they were under the Federal Poverty Level.

And to Sheila's point, if you are going to the pharmacy and you don't have that dollar in your pocket and you're turned away, that can cause a lot of problems and really get people off track in terms of their care plan.

So, we want to make sure because pharmacies don't use the MMIS system, don't know people's income, we want to make sure that people aren't being turned away.

So, there's just a number of things that we think can be communicated, and changes to presumptive eligibility is another example.

So, with that, I will read the recommendations from the past two meetings. Our recommendations from October 20th, the first is that DMS provide guidance to pharmacies related to charging Medicaid copays and rules around turning

Medicaid beneficiaries away for inability to pay.

The second is that DMS communicate any changes in presumptive eligibility periods or end dates with Connectors.

The third, that DMS provide DCBS workers and Connectors with talking points on the Public Charge Rule that they can reference when asked questions.

And the fourth has actually already been addressed, but it's that the Social Security number not be a required field on the public-facing presumptive eligibility application, and that has been taken care of, so, we really appreciate that.

Our recommendations from our December 15th meeting, the first, that DMS make corrections to the Kynect SSP, the Self-Service Portal, related to the least-restrictive identity proofing.

A lot of people have gotten kind of caught up with their applications (inaudible) because of identity proofing, and that DMS stop the MMIS override related to middle initial and mailing address matching. These are issues that have been going on for a long time.

The second recommendation, that DMS add a box to the presumptive eligibility application indicating the individuals who don't have a Social Security number in order for them to continue the application. This one actually has been addressed along with the previous recommendation that I noted.

The third, that DMS remove the term citizen from the presumptive eligibility application and instead call it the Kentucky Health Care Application.

And the fourth, that DMS educate providers on the availability of emergency time-limited Medicaid for COVID-19-related testing, treatment and vaccination, and we have been having some good conversations about that.

So, the next Consumer TAC meeting will be on February 16th at 1:30, and we have our future meeting dates on our report as well.

And, Dr. Partin, I emailed you a copy of this report and also you, Sharley, earlier this morning. Thank you.

DR. PARTIN: Thank you, Emily. Anybody have questions? Thank you.

Next is Dental.

DR. BOBROWSKI: Yes. This is Dr. Garth Bobrowski. I wanted to kind of give you a brief rundown of our last TAC meeting and I wanted to bring your attention to some issues that dentistry is facing.

And, first, I wanted to acknowledge that I feel honored for our contacts within our Administration, our Commissioner and Deputy Commissioners, that I feel like we've got a good line of communication going on.

But I also wanted to share that just like with Ms. Sheila down there, she's having some frustrations. Well, dentistry is having frustrations, also, and I don't have time today to go through it all.

But I was on a conference call Tuesday with the Kentucky Dental Association's Executive Committee and other folks. Their offices there and the KDA president are getting numerous phone calls of just multiple frustrations.

This is hard because many are having to admit financial frustrations with their viability to keeping offices open.

And we've talked about this earlier about access to care and there's a lot of

frustrations with the economics of it. I won't go into a lot of details here right now, and I got a call this morning, at 6:30 this morning from another dentist of an oral surgeon's office that is having to let go one of their associates because of financial stuff that they can't do with Medicaid anymore.

In December, I had another call from out in the western part of the state that they're about ready to have to let an associate go in their dental clinic which is a big percentage - 80, 90% Medicaid dental office, but there's a lot of frustrations going on.

And we have another meeting set up on February 12th with our TAC and hopefully we'll be able to bring some recommendations forward at that time.

I had a whole page of notes here. I won't go through all of that right now but some major problems with recoupments. It's like the dentists are treated as guilty requesting tens of thousands of dollars in recoupments. So, you're guilty and, then, you have to prove your innocence.

Well, when you go through the recoupment process, well, they're knocking off tens of thousands of dollars off their bill but they're

being treated as - you know, they've got to go back through at least two years and sometimes five years of charts and x-rays to prove it but they prove it and they're fine but it's just the idea of being guilty and, then, you have to prove your innocence.

So, we've got some things to work on but I won't take up anymore time today and thank you very much.

DR. PARTIN: Thank you. Any questions? Then, we're going to move on to Nursing Home.

MS. HUGHES: They haven't met.

DR. PARTIN: Okay. Home Health.

MS. STEWART: Susan Stewart. Our TAC continues to meet and we have no recommendations at this time. Thank you.

DR. PARTIN: Hospital.

MS. HUGHES: They are having a meeting later this month.

DR. PARTIN: Okay. Intellectual and Developmental Disabilities.

MS. HUGHES: They did meet but I guess they're just not here to present.

DR. PARTIN: Okay. Nursing TAC did not meet. Optometry.

DR. COMPTON: Steve Compton with the Optometric TAC. We have not. We meet next week on February 4th.

DR. PARTIN: Thank you. Pharmacy.

DR. HANNA: We didn't meet. I think the last one was in November.

DR. PARTIN: Thank you. Physician Services.

DR. GUPTA: Ashima Gupta. The meeting was January 22nd and we mostly discussed telemedicine and we have no recommendations at this time.

DR. PARTIN: Thank you. Podiatry.

DR. ROBERTS: No recent TAC meeting but I appreciate Lee Guice's help with the skin biopsy issue.

DR. PARTIN: Thank you. Primary Care.

MR. CAUDILL: Again, Madam Chairperson, members of the MAC Committee and Commissioner Lee, I'm Mike Caudill. I'm the CEO of Mountain Comprehensive Health Corporation, a QHC based out of Whitesburg, Kentucky and Chairperson for

the PC TAC.

We did meet. The last meeting was January 7th. Out of that meeting, there was no recommendations for the MAC committee. Half of what we spent our time on was concerning the wrap/ crossover claims cleanup with Commissioner Lee's DMS.

What came out of that is, if I may, FQHC's and RHC's get paid on a different system. It's not a fee system. It's a PPS rate, prospective pay system.

Since the MCOs came into being in 2011, payment of the PPS rate has been a two-part process with the MCOs paying a fee rate which is usually less than the PPS rate, and, then, DMS pays the difference to the FQHC's, RHC's in what is commonly called a wrap payment.

This process has had problems concerning the accurate and timely payment of these wrap payments since their inception.

There was a major change that was an improvement that happened on July 1st, 2014 but problems still persist.

DMS has recognized this. They're recognized that there's critically old claims and encounters sitting out there where the

appropriate wrap hasn't been paid.

DMS is in the process of a deep dive to better understand what is going on with the wrap by the process of identifying root causes that continue to prevent the wrap payment from being generated.

To this end, DMS is working towards pulling together a workgroup made up of DMS, MCOs and KPCA and select providers to identify the problems and potential solutions to those problems which will then clear the way for a reconciliation.

DMS' stated goal to the TAC is to ensure claims and the wrap payments get paid appropriately to the extent possible.

At our January 7th meeting, DMS also identified they were in the process of development of guidance and FAQ's and a webinar on how to bill wrap payment and what the process would look like from the perspective of all three - DMS, the MCOs and of the providers - so that everyone has a clear understanding of how it works, the proper way to submit a claim and what are the coming problems.

In addition, DMS told us they had met with Texas officials to review their model which has been suggested by KPCA as a possible model

to help with this process, and that model has since changed as a result of lawsuits and DMS does not feel that would be a workable model for them.

Other issues discussed was a 30-site NPI limitation. An update was requested but was not available at that time. It seems that Ms. Hackett of DMS has been assigned that and she was not on the call and available to contact at that time.

Our next meeting date is March 4th at 10:00 a.m., and by that time, DMS has promised that there would be substantial progress made on being able to get the parties together and work on these solutions and we're certainly looking forward to that.

And we appreciate DMS, its staff and their continuing to work with the PC TAC, the KPCA and the individual providers as partners on trying to resolve these issues and to make progress on the other issues, and that's my report, Madam Chairman.

DR. PARTIN: Thank you. Any questions? Okay. Then, let's move on to Therapy Services.

DR. ENNIS: Thank you, Dr. Partin. Beth Ennis, Chair of the Therapy TAC.

We met on January 12th. All members were present. I did submit a written document with our recommendations listing many examples but it's very similar to what I'm hearing from everyone else.

We're having continued significant issues with administrative burden from various different issues that I'm not going to take the time to go into here because of our time.

Our recommendation, though, is that a task force be put together to look at administrative burden issues and provide some suggested solutions related to payment, prior authorization, all of these different areas.

We had stated it in our recommendation as specific to Therapy but it sounds like it could be something that could be used across multiple disciplines, given the number of issues that we're hearing across provider types today, and I will let my document stand as received for the rest of the information.

We're going to meet again in March and our dates are on the website. Thank you.

DR. PARTIN: Thank you very much.

Before we move on, Sharley, the packets that we used to receive used to be on the website and they haven't been, and I was wondering if we could start that process again.

MS. HUGHES: We'll have to get with the Commissioner and so forth and go through that. That's not been out there for probably two years. So, I will get with them and see what we can come up with to put out there.

DR. PARTIN: Okay. I appreciate it. Thank you.

MS. HUGHES: And, Beth, if we can get United Healthcare to do their presentation next - I can't remember if they were next or not - but I think they have several people on the call that they've called in for this presentation and I know we're close on time.

DR. PARTIN: Yes, they are next up on the agenda. Let me ask them. We definitely want to hear from you, especially because you're new to Kentucky and we're eager to hear your information.

We have about twenty minutes left for the meeting and we have another item on the agenda to address.

So, I will ask United

Healthcare, if you think you can do your presentation in fifteen minutes, that would be fine; but if it's going to take a little bit longer than that and I assume it might, then, would you mind going to the next meeting?

MS. BATES: Dr. Partin, I believe they're going to make it a shorter version, and I wanted to give them the opportunity to do a short presentation, but, then, more importantly, to address questions that we've gotten from the provider community. I believe there's some people on this that would like to ask them some questions.

So, I'm not sure who with United was going to present. Keith, I don't know if you want to speak to that, but I do want to give you an opportunity to briefly present and, then, answer some questions.

MR. PAYET: Thank you, Deputy Commissioner. We can quickly go over a high-level slide review. I do want my team to present so you all can hear about our clinical programs and what we're doing in terms of engaging in communities.

So, we could do our best to get this done as quickly as possible and just want you all to meet our leadership team here. Being the new

MCO in the community, I think it's important for you all to get to learn who your potential contacts are and who you will intersect with over time. So, I think we can accomplish what you're looking to do here.

So, I'll move through the overview slides really quickly, if you could just go to the next one.

First, let me just say good afternoon and thank you for the opportunity to meet with all of you. We're very excited to serve the Medicaid population and continue to develop partnerships with our provider community and community agencies as well.

I'm Keith Payet. I am the CEO for the UHC Community Plan of Kentucky. We plan on sharing with you a high-level overview of our organization but we'll cover a few items here. You see the agenda. We'll go through our member-centered care. We'll talk about our provider partnerships, integrated clinical model, pop health quality, and what we're doing in terms of community engagement.

We have other lines of business as well which is our commercial and our Medicare. So, we're not new as an organization but we're new in

terms of servicing the Medicaid population going live 1/1/21.

Go to the next slide. Let me just quickly introduce you to the leadership team. Our COO is Rebecca, who goes by Becky, Bolling. We have our CFO, Michael Lines. Our Chief Medical Officer is Dr. Jeb Teichman. We have our Medical Director, Dr. Divya Cantor, and we have our Behavioral Health Director, Dr. Lisa Cook, and we have Suzanne Lewis who is overseeing our Pop Health Program for the health plan.

Next slide. Our mission at UHC is centered around the people we serve, the community-based care system and our state partners.

We are in the business of helping people live healthier lives and making the health system work better for everyone, and that's delivery simplicity, being catalysts for person-centered, community-based health transformation, and it's all centered around trusted partnerships with our stakeholders.

And you'll see right here in this slide we put our stakeholders in the center of everything that we do.

Next slide. I'll kind of get

ahead of the next slide here. We support various Medicaid populations across the country. You will see in the dark blue here, that's our Medicaid footprint. We have thirty-two states that we're supporting today through multiple programs - your traditional Medicaid. We have LTSS, intellectual and/or developmental disability programs, foster care, ACA expansion markets, DSNP, and fully integrated dual-eligible programs that we bring to market across the country.

The value in having such a broad footprint, for Kentucky, for example, it allows us to leverage knowledge, broad leadership across state programs, ideas around program design, innovation opportunities, technical expertise, partnerships with community providers around, for example, payment methodology and systems and community supports as well.

Next slide. So, I know I went over that fairly quickly but I'm being consciousness of time here. So, I will turn it over to Dr. Teichman. Thank you.

DR. TEICHMAN: Good afternoon, everyone. My name is Jeb Teichman. I'm the Chief Medical Officer for United Health Community Plan of

Kentucky.

I just want to introduce myself really quickly. I'm a pediatrician by trade. I've spent virtually my entire clinical career serving the folks of Southern Indiana and the Commonwealth of Kentucky. I have been in full-time managed Medicaid care in Kentucky for the last eight years and I'm really happy to be with United Healthcare as their CMO for this year.

In the interest of time, I'll just quickly go over the access to care for our members. These are the covered services. They're not an entirety. We cover all services that are required by our contract with the State.

Next slide, please. Members can access information about their plan on our website and an app and they can also call Member Services.

Providers can get more information about the plan at uhcprovider.com/ky. That gives a lot of information about our resources, about our coverage, our prior authorization processes and contact information.

Next slide, please. This is a list of our value-added services. I won't go through them all in detail. I just want to point out that we

do cover as a value-added acupuncture services and have various programs to address pregnancy, reward programs that reward our members for addressing needed care and participating in our programs.

Next slide, please. Now I'll hand it over to our Provider Relations Team.

MS. SMITH: Thank you, Dr. Teichman. Good morning. My name is Jen Smith. I'm the Manager of Provider Relations.

I think this slide is pretty self-explanatory. This is our map for our Provider Relations Team. We do service only the medical providers in Kentucky. We do have a separate team who handles our dental, vision and our behavioral health providers.

Next slide, Sharley. Now I want to talk a little bit about our claim dispute resolution process or our service model.

The first step in our service model allows for our providers to submit a claim reconsideration when a claim does not process the way that a provider anticipates. And the preferred method for submission of the reconsideration is to utilize Link which is one of our self-service tools. Link is electronic and it allows providers to track

their reconsideration through the process, and it also allows providers to flag those reconsiderations for followup.

If Link is not an option for a particular provider, they can also mail in a paper form to the Claims' mailing address or they can also call Customer Service.

Next slide. So, after reconsideration, if the claim were to still remain unresolved, provides would then work with our Claims Advocacy Team. So, what they would do is they would send an email to the address indicated here and that email would be picked up by a dedicated team who would begin researching the claim.

If it was determined that the claim had, indeed, failed our system, that team would escalate the claim for adjudication and, then, they would respond back providing some payment information.

If it was determined that the claim had processed appropriately, they would respond back with education, and if possibly the claim had maybe bumped up against a particular medical or reimbursement policy, they would respond back with a link to that policy and provide information to

educate that provider so that moving forward, they would understand why that particular claim had failed.

One of the things I do want to point out about our service model is that we ask providers to submit only one reconsideration and, then, we're going to take it from there.

So, providers do not have to make multiple phone calls into Customer Service or multiple attempts to resolve their claim. Submit one reconsideration and, then, you can send an email into our Claims Advocacy Team and we're going to take it from there.

We're very, very proud of this process and we're very proud of this team. We've received a lot of feedback from our providers who really, really like this expedited process.

Next slide. So, we have a wealth of knowledge regarding our prior authorizations and notifications available on our portal. And one of the benefits surrounding our prior authorizations and notifications is we do have another self-service tool which is PAAN, Prior Authorizations and Notifications, and it allows our providers to submit their requests electronically.

Something else that we do have which our providers find very helpful is an authorization list. It's a searchable document. So, providers can quickly go in and at their fingertips they can see which specific CPT codes or HCPC codes require authorizations.

Next slide, please. This provides the pathway for our provider manual. Again, this is a searchable document. It's an excellent resource for our providers. It's usually the first place that we recommend that providers go to look for answers to their questions.

Next slide. So, United Healthcare actually has two portals. We have UHCprovider.com which is our non-secure site. This is where we house our general information, bulletins, medical and reimbursement policies, training information.

And, then, we also have Link which is our secure site. This is where all of our PHI information is housed. This is where you're going to find eligibility and benefits, claims data. This is where you're going to do your claim reconsiderations. If you're a PCP, this is where you're going to go to find member reports.

We do have a corporate trainer who offers excellent training, and, then, always any of the advocates on my team, they're available to assist with navigation should those needs arise.

Next slide. And, then, any providers who are interested in pursuing a contract or who might have questions about an existing contract, any of their contact information is located here.

Next slide. Some numbers and hours of operation for our Provider Member Services and OBH can be found on this slide.

Next slide, please. Training. So, beginning next week, we are going to begin offering a monthly training series. It will be on a variety of topics, and we will also offer provider town halls and/or provider information expos. Those are going to be held in various geographical locations throughout the state.

While they're geared at the collections and billing staff, because we talk about our service model, claim resolution, we also do like to invite our clinical staff because we sprinkle in discussions about authorizations and quality topics.

And something that is not

mentioned on this slide is we have been hosting since the first week of January our provider orientation webinars. Those are going to be held through the second week of March. We have been covering general information about the community plan offerings, about how to do business with us such as our service model and resources available to our providers.

So, that wraps it up for me. Now I'd like to turn it over to Suzanne Lewis who is our Director of Population Health Services. Suzanne.

MS. LEWIS: Thank you. My name is Suzanne Lewis and I'm the Population Health Director. I'm a registered nurse and a Certified Case Manager and I've been in managed care for about eighteen years.

At United, our approach to population health incorporates best practices for both the population and individual-based care, emphasizing the whole individual, and this includes the enrollee's background, their background and their culture.

Our programs are really focused on relevant health education, preventive care, telephonic and face-to-face care management, and transition management.

The goals for our program for population health include improving access to preventive care, empowering enrollees to become successful in managing their conditions, and improving care coordination through our dedicated staff to help with access to care, care transitions and, then, identification of community resources to assist our enrollees.

Our population health programs have targeted outreach initiatives to assist our enrollees to improve their quality of life and support healthy lifestyles through condition education, preventive health education and initiatives, and manage chronic conditions.

Our goal is really to help provide opportunities to connect with community programs and partnerships for health education programs.

The next slide, please. Thank you. Population health programs, for identification, we look through a variety of sources for our members. We look at medical and behavioral claims, pharmacy, lab claims. Every effort is made to identify and refer enrollees into our programs.

We have tools like health risk

assessment. We collect data from the UM process, utilization management process. We also have clinical rounds with our inpatient case management team and our other clinical teams, and we use information tat's supplied by our members and our providers to help us identify enrollees.

We use different criteria for identification of our population that's responsible for the significant portion of health care spending.

The criteria we use includes ER utilization, specific chronic health conditions or frequent hospitalizations. We look for enrollees that are at highest risk for re-admission, complex care needs and coordination of services, individuals with catastrophic diagnoses or chronic illness that require complex medical care.

Once our members are identified for care management through our risk stratification tools and models, our integrated behavioral health and medical care management model is deployed.

We have our clinical care managers who are focused on engaging our members in the program, providing care coordination for complex illnesses, and, then, supporting our enrolles in providing health outcome, improving health outcomes.

Each enrollee in our complex care management program is provided with a local care manager. We have a team dedicated here in Kentucky who act as the primary point of contact, and the case manager, then, engages an integrated care team to support the enrollee's needs.

We use the multi-disciplinary care team approach. Our care managers engage the enrollee in completing a needs assessment and the assessment is used to identify gaps in care and discuss with the enrollee the goals and objectives to developing a care plan.

And, then, once our member's needs are identified, we pull the right team members into that multi-disciplinary care team and bring them into clinical rounds to engage in finding the right resources, interventions and contacts to support the member.

We do hold daily rounds and weekly multi-disciplinary care team rounds where members from our utilization management, case management, behavioral health, pharmacy, our Medical Directors, we have a social determinants of health advocate, we have enrollee services and others will join to assist in developing the right interventions

for our enrollees.

Next slide, please. So, this is the member story. And I'm not going to go through the entire thing, but I did just want to point out that if you get to look at these slides, this is how a member is identified from the point of the inpatient stay, when a member comes in to the hospital and is identified through their admission all the way to referring to the case manager, developing a plan of care, supporting that member and getting them the resources and services that they need to close some of their most immediate care gaps.

And in this case, we had some immediate care gaps that were addressed through a multi-disciplinary care team.

So, we'll go on and move to the next slide and that's my last slide. And this is just a map of Kentucky that shows the location of all of our different team members. We have behavioral health case managers, case managers, social workers. I have clinical administrative coordinators and also community health workers located throughout the state.

Right now, we are currently opening positions in some of the other parts of our

state as we staff up for the areas where we have most of our population. So, this is just a visual of where our staff is located here in Kentucky.

That's the end of my presentation. So, I will let the next person go.

DR. COOK: Good afternoon. This is Dr. Lisa Cook, and I'm going to briefly just review our Model of Care for behavioral health.

So, our behavioral health program is based on an integrated population health approach. Our goal is to address the whole person in integrated care.

We leverage our internal partners, physical health, pharmacy, dental, as well as our social determinants of health and our recovery and resiliency team members to make sure that we are addressing every aspect of our member's lives to support and foster positive behavioral health outcomes.

We're evidence-based. Our utilization review activities are based on objective, evidence-based, nationally-recognized medical policies and clinical guidelines and criteria.

Our complex case management program, it is aligned with NCQA standards, as well

as we use evidence-based data analytics to look for those members who have high utilization, co-occurring behavioral health and substance use disorder conditions, as well as co-occurring conditions.

We have a collaborative integration care approach and coordination. We think about our providers. We work really diligently to ensure that there is collaborative communication and care across the scope of behavioral health and our medical health providers.

Further within behavioral health, we have all levels of care. And, so, our in-network providers, as our members move through the continuum of care, we make sure that there is coordination between those members moving to high levels of care, transitioning down to lower levels of care and conversely.

We are recovery- and resiliency-focused. Our utilization teams and our care management teams, we really work to allow our members to lead their recovery from their perspective.

So, they're driving that and they're leading us, and, so, we allow that, and we really support our providers in that effort as well.

The next slide, please. The next slide we'll go over our behavioral health/ substance use disorder program. So, what you can expect, our behavioral benefits will be inclusive of mental health and substance use services.

You should expect to see everything that's aligned with what the State has already provided within the behavioral health/ substance use fee schedules, those benefits. That's what you expect to experience within our program.

We are continually building up a robust behavioral provider network to support collaboration and continuity of care.

Our goal is to ensure that we have access to care by making sure we address all those provider types, our community mental health centers, our behavioral and substance use organizations, our multi-specialty groups, etcetera.

We want to make sure that we are supporting that collaboration and access to care to making sure we're contracting with those behavioral providers in our network.

Our comprehensive utilization management program, we will administer inpatient and outpatient services. We definitely monitor and

facilitate a high-quality, individualized care perspective to make sure that we are addressing our members appropriately for care.

We also make sure that we utilize ASAM criteria for the substance use disorder to make sure that we are authorizing the appropriate interventions.

We utilize InterQual for our behavioral health, mental health services as well.

Equally, we have an integrated complex care model. We are addressing and targeting those Kentucky enrollees with seriously mental health illnesses, our children with seriously emotional disorders, as well as those enrollees who have high care needs and special health care conditions.

We also look at making sure that we address those members who have those co-occurring substance use disorders.

Again, I mentioned that we are recovery-focused. And, so, we allow our teams to be driven by our enrollees to take leadership in that perspective.

We have a provider relations advocate team. We view our providers as partners. And, so, we will work to educate and support our

behavioral providers through navigation with us.

The last thing I want to talk about is how excited we are to have value-based payment arrangement opportunities here in Kentucky. We are looking forward to having that innovative collaborative and creative opportunities to really provide wraparound services for any gaps that we find that our members are having to make sure we can build community stabilization.

The next slide. So, this slide just shows our behavioral health provider relations team. We've already addressed the medical team. And, so, you can look at this slide and it gives you the different regions and the contact information that you would reach out to if you had a provider relations' question or issue.

And, then, for any type of issues or resolution that we don't find happens within the local team here, the region appointees, you can always reach out to the Director, Amanda Gloeckner, who can help you as well.

So, I spoke fairly quickly. I thank you for your time today, and I'll turn it over to Angela to talk about our quality.

MS. BREDENKAMP: I know we're a

little over time, so, I'll just go briefly over this slide. It's just a high overview of what our strategic goals are for quality and making sure we are implementing it throughout our health plan.

We are working with our providers and practitioners to provide a high level of care, identifying and analyzing opportunities for improvement, coordinating our quality improvement, risk management, patient safety and operational activities, maintaining compliance with local, state and federal regulatory requirements, as well as achieving accreditation standards to NCQA.

We're ensuring that we're meeting our culturally and linguistically needs of our diverse population and monitoring and improving our quality indicators.

And we support our members living healthier lives, including those with multiple complex illnesses and look for opportunities of improvement.

I think I'll move on to the next slide and it might go back to Keith maybe.

MR. PAYET: We'll just close really quickly but I just wanted to share. On this slide, you'll see some updates in terms of how we've

engaged the community as of yet.

We've gone through and done some community donations addressing some of the unmet needs within the community, food insecurities, school supplies, homeless outreach and transportation.

We've also participated in the Community Computers Program which addresses the needs of technology in vulnerable populations that we're seeing across the Commonwealth, the Kinship Caregiver Guidebooks, partnering with Kentucky Youth Advocates on printing and distribution throughout the state as well.

Again, you'll see a list here, and most recently in priority, we've really been gearing and supporting the needs around the COVID response, handing out hand sanitizer. We have plans also to go out in the community and help with the vaccinations as well.

So, we really will wrap around the community as part of our effort and continue priorities as well.

Let me just close out by saying this since we really are over time. One, thank you for the opportunity to present to you all today. It was really important for you all to hear and meet the

individuals for which you will be in contact with. Also, you will see with the slides, all of the individuals for which you may need support, questions, how members may contact us, how providers may contact us, all that information is captured here. So, feel free to share that information.

We're here to be your partner. That's a priority, communication and working together, and we're really excited to be part of this community and support the people of the Kentucky Commonwealth.

So, we'll close it there and thank you.

DR. PARTIN: Thank you very much. Sharley indicated that people had questions.

MS. BATES: This is Stephanie. I just wanted to give an opportunity - I know Dr. Cook or Keith or Dr. Teichman, any questions.

We've had questions from particularly the behavioral health community but others about network. I know Steve Shannon was on. I'm not sure if he's still on, but if there are any questions, now would be the time to ask directly to the leadership of United.

MR. SHANNON: This is Steve

Shannon. Thanks, Stephanie.

The KARP Association is made up of eleven of the fourteen mental health centers and I'm in contact with all fourteen. And as of the end of last week and middle of this week, there are still some concerns about the status of contracts.

It looks like most of the centers, some do. We've acknowledged that. Four or five reported contracts with Medicaid Managed Care. Many have contracts with United for other services, other lines of business but not for the Medicaid Managed Care piece and they're getting a little anxious that we're the first month in and the contracts aren't worked out yet. They're not resolved. They're waiting to hear back, have been communicating back and forth.

So, overall, some folks have been frustrated with the contract process working with the team at United but hopefully this gets resolved soon.

I understand they should be getting 100% of the Medicaid fee schedule for ninety days, but they want to have a contract in place and that hasn't been resolved yet and they're concerned about that. So, thank you, Stephanie, for that

opportunity.

DR. SMITH: Thank you. This is Dr. Cook. So, I am aware and I'll let also Amanda Gloeckner speak as well, but we have been working really diligently to expedite those contracts with our behavioral partners and the providers in the community.

So, I think, specifically, if there's concerns that we can address, we can definitely set up a call but I know that our contracting team has been working to make sure we're moving through that process to address the concerns with the contracting.

MR. SHANNON: Thank you. We started this process back in the fall, so, that's part of the frustration.

DR. LEWIS: Oh, I understand.

MR. SHANNON: And it's got a hand up the last two or three weeks but people felt - one person had no contact from United at all until late November or early December when it was go live 1/1.

That's a concern. I don't think that's a great way to start a relationship and I think that's what people are getting really

concerned about. Where are we? What's the status? When will this be resolved?

DR. LEWIS: So, yes. Let me apologize for any of those delays and we really do value the community mental health providers in the community and all of the behavioral providers.

And, so, we are working, as I noted, to make sure we're moving those through. And, so, again, if there's specific concerns you have that you want to address with me or address with our contracting team, we can definitely do that to make sure that we're addressing everything.

So, please feel free to reach out to myself or Amanda Gloeckner and we can make sure we resolve that for you and follow up immediately. Okay?

MR. SHANNON: All right. Thank you.

DR. LEWIS: You're welcome.

DR. PARTIN: Steve, that's a good point in that the contract issue is also, I think, with other providers outside of the behavioral health community. I know our clinic has had difficulty with the contract and with some of the requirements that they're asking for. Their requests

are not requests that are made by other companies - let me put it that way - and it's making it more difficult to complete the application.

And we also started the process back last fall and still are not current. So, I'd like to echo that same concern.

MR. PAYET: Let me just add. We're working diligently. We do have a workforce in the community trying to address these as quickly as possible, but we're aware that there are asks out there. And when they do come in, we do prioritize and do work around there.

I think the big message here is that we do want to work with you. We are working with many of you through this process. And any concerns, please just reach out.

We are, like I said, prioritizing and addressing these as they come in, understanding that we've gone statewide to develop the full network. So, there's a lot of pieces going on at the same time, but I understand your frustration and we'll continue to work through those.

DR. PARTIN: Since you went live on the 1st of January and we're having difficulty getting the credentialing done, when it's finally

completed, will you all backdate the reimbursement to the first of the year?

MR. PAYET: Where is my contracting team?

MR. SHANNON: A great question, Dr. Partin. I've been asked that a lot since January.

MR. BURNS: This is Kris Burns. Margaret had to exit for another call. We'd be happy to discuss that with you. If you'd like to set up some time with your contractor, whoever you're going through negotiations with, we'd be happy to talk about that on an individual basis.

DR. PARTIN: I guess since it's a universal problem, it's just another hoop that we're having to jump through, I would ask that it just automatically, once we're credentialed, that we're paid back to the 1st and that we don't each have to individually try to connect with somebody to get that done. I mean, that's just another hassle, another hoop and we're all busy people trying to work in our clinics.

So, I would ask that we don't have to individually do that and that you automatically do that.

MR. BURNS: Thank you. That

feedback is duly noted. And I just found out from Dr. Cook - I believe we are doing that on the behavioral health side, but I'd be happy to take that as a takeaway and let you know.

DR. PARTIN: I appreciate it. Thank you.

MR. PAYET: Thank you all.

DR. PARTIN: Any other questions? Stephanie, did you have any other feedback from people about questions that haven't been asked?

MS. BATES: No, I don't think so.

DR. PARTIN: Okay. Then, we will move on.

We have one item of New Business and one of our MAC members had a question about IMD issues for freestanding behavioral health hospitals and the resulting lack of MCO adherence to payment regarding Managed Care Medicaid.

So, would you like to speak to that?

MS. EISNER: Yes. This is Nina Eisner and that's my issue. Do we have time for this agenda item today? I can't do it in two minutes, for

example. Should I go directly to Commissioner Lee and Deputy Commissioner Bates and maybe bring it back next time? I just want to be sensitive to everyone's time. I'm happy to do it today.

DR. PARTIN: How much time do you need, Nina?

MS. EISNER: I'd say at least five minutes.

DR. PARTIN: Okay. Go ahead and take five minutes.

MS. EISNER: Okay. The issue that I'm bringing forward is basically to clarify what is an IMD and the Managed Care Medicaid policy according to 42 CFR Part 438, Subparts A through J which are specific to emergency medical conditions and payment in IMD's.

I don't know if everyone knows what IMD's are. This goes back fifty-five years, even longer than my forty-seven years in this business, and it basically started in 1965 when the Social Security Act prohibited payments for (inaudible) services for patients between twenty-one and sixty-four in a freestanding, more than 16-bed facility.

For mental health and

behavioral health back then, most of the care was provided in great big state hospitals like Eastern State, the second oldest in the country.

And it wasn't until the eighties and the nineties that freestanding behavioral health hospitals really became more present.

In 2011, as part of the ACA, the federal government created a five-year Medicaid Emergency Psychiatric Demonstration Project which was in eleven states and the District of Columbia.

That was basically a removal of restrictions from select IMD's to evaluate whether or not Medicaid could lower the cost and provide better care and access to people with psychiatric illnesses if the IMD exclusion went away.

In 2016, CMS finalized that rule permitting Managed Medicaid MCOs to receive reimbursement for acute care less than fifteen days per month provided in an IMD, and this was the first major update to Medicaid and CHIP Managed Care regulations in more than a decade.

The final rule allows MCOs to be paid in states who claim FFP for patients who spend less than fifteen days a month in an IMD, if

clinically appropriate, and that's always expected - clinical appropriateness.

The unintended consequence of that, however, was that in some states, if those were not paying for stays beyond fifteen days and they clawed back from providers if the stay went over fifteen days.

Now, I am pleased to tell you that I have not discovered that that was a problem in the Commonwealth.

In November of '20, CMS clarified regarding Managed Care Plans the 15-day policy and this was just a few months ago. CMS cited with IMD's pointing out that there was no regulatory requirement for IMD's to reimburse MCOs for care provided beyond fifteen days.

October of '18, there's another legislative initiative going on and that was the Support for Patients and Communities Act of 2018 which was signed into law to prevent and combat substance use disorders.

Among many provisions, the Support Act modified the Medicaid IMD exclusion to lift some of the restrictions using Medicaid IMD exclusion for treatment of SUD, but it did place a

30-day limit on lengths of stay.

And the next wave of rules and regs regarding IMD's was November 1, 2017 when CMS sent letters to State Medicaid Directors revising the guidance to allow states to use 1115 Waivers to pay for SUD and IMD's.

The Commonwealth, I think, is very progressive in this regard. And in November, 2018, CMS issued new guidance inviting states to apply for 1115 Waivers of federal IMD payments exclusions for services for adults with SMI.

And the takeaway was that the 1115 Waiver's federal funds could be accessed as long as all patients instate were receiving treatment in IMD's of thirty days or less.

I'm a paper geek. So, I have all the documents. I've been here since 2002 in this position. And, Stephanie and Lisa, you all know, you've been very progressive in this regard.

But herein lies the problem. Everything that I told you about IMD's allows patients between twenty-one and sixty-four to be cared for and paid for in an IMD.

There is a parallel issue with Managed Care Medicaid policy 42 CFR Part 438,

Subparts A through J, and the focus specifically that I'm bringing is Subpart C which deals with emergency and post-stabilization services.

This regulation defines emergency and post-stabilization services as medical conditions manifesting itself by acute symptoms of sufficient severity that a prudent lay person could expect the absence of immediate medical attention to result in, among other things, placing the patient's health and individual in serious jeopardy.

Part B said that coverage and payment, the general rule was that certain entities including MCOs are responsible for coverage and payment of emergency services and post-stabilization services.

Inpatient and outpatient services furnished by qualified providers to evaluate and treat and stabilize an emergency medical condition, the MCO must cover and pay for emergency services regardless of whether or not the provider furnishing those services has a contract with the MCO. And I want to reiterate we're talking about emergency medical conditions.

Under EMTALA, the emergency services coverage requirements for Managed Care

Medicaid, a CMS memo dated July 2nd, 2019 outlines IMD requirements to treat emergency medical conditions and says that when an emergency medical condition exists, the MCO must pay whether that IMD is contracted or not.

It cannot require prior auth for emergency conditions and they cannot limit what constitutes emergency conditions.

So, in my presentation now, what I'm telling you is that from my perspective, emergency medical conditions must be paid for in an IMD whether or not there's a contract as long as it is an emergency condition.

I'll give you that in the industry, there is still some ambivalence and I think still some lack of clarity about those post-stabilization services after the emergency, but in my mind, the law is clear. The language is not subject to interpretation, and I believe that we have some violations of not just the intent but the absolute regulations and everything that's come down from CMS.

Our goal is simply to approve access to high-quality, cost-efficient care in the moment to facilities that can focus on the necessary care and deliver the best possible outcomes, and

that's about as fast as I can talk.

DR. PARTIN: Can we take that as a recommendation from a MAC member?

MS. EISNER: Yes. And I'm sorry I didn't do a slide, Sharley. I can send you a summary of all my comments if you want.

DR. PARTIN: That would be really helpful, I think, because the rest of us are probably not real familiar with all of the statutes and regulations and acronyms that you used. So, that would be very helpful.

MS. EISNER: I will do that.

DR. PARTIN: Okay. So, we have recommendations from the TACs and we have recommendations from a MAC member. And, so, we need to vote to approve those and get them sent to DMS for a response.

So, would somebody like to make a motion to accept all of the recommendations today?

MS. ROARK: I make a motion to accept.

DR. PARTIN: Peggy. A second?

DR. COMPTON: Steve Compton. I'll second.

DR. PARTIN: Any discussion?

All in favor, say aye. Any opposed? So moved. Thank you.

Any other New Business? I appreciate everybody's patience. We went over about twenty-five minutes but we have gotten some really good information today and I appreciate everybody's patience and I appreciate everybody who brought the information to the meeting. I think it's been very useful.

So, with that, motion to adjourn.

DR. HANNA: So moved.

MS. EISNER: Second.

DR. PARTIN: I don't think there's any discussion, but if there is, please raise it now. Then, all in favor, say aye. Anybody opposed? So moved. Thank you very much and we will see each other again in March.

MEETING ADJOURNED

STATE OF KENTUCKY

COUNTY OF FRANKLIN

I, Terri Pelosi, a notary public in and for the state and county aforesaid, do hereby certify that the foregoing pages are a true, correct and complete transcript of the proceedings taken down by me in the above-styled matter at the time and place as set out in the caption hereof; that the proceedings were taken down by me in shorthand and afterwards transcribed by me; and that the appearances were as set out in the caption hereof.

Given under my hand as notary public aforesaid, this the 5th day of February, 2021.

_____
Notary Public
Notary ID KYNP21661
State of Kentucky at Large

My commission expires February 10, 2025.